DEPARTMENT OF HEALTH AND
COMMUNITY SERVICES

RISK MANAGEMENT SYSTEM

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- **Charline LeBlanc**
- **Martine Levasseur**
- **Gerry McHugh**
- **Yvonne Vautour**
- **Reno LeBouthillier**
- **Edith LeBlanc**
- **Mary McCormack**
- **Marie Petruska**
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MODULE I

INTRODUCTION TO RISK MANAGEMENT

MODULE I

INTRODUCTION TO RISK MANAGEMENT

THE NEED FOR IMPROVED RISK MANAGEMENT IN CHILD PROTECTION SERVICES

Over the past decade, increased attention has been given to how the risk of abuse and neglect is assessed and managed within the field of child welfare. There is a broad consensus that the organizations and agencies which provide child protection services need to improve their approach to risk assessment and risk management. Many factors are responsible for this development. The major impetus for improved risk assessment and risk management includes:

1. CHILD PROTECTIVE SERVICES ARE FACING NEW AND DIFFICULT CHALLENGES

- Continued and significant increases in the number of reports of child abuse and neglect
- Restraints on financial and human resources (budgets and staffing)
- Increasing and high caseloads
- More complex, serious and multi-problem cases
- Increased accountability, greater scrutiny and external review mechanisms

2. LEGAL TRENDS AND CHANGES

- Revisions of child welfare legislation to include risk of harm or abuse as grounds for finding a child in need of protection
- Increased liability in child welfare practice

3. INCREASED RECOGNITION THAT MOST CHILD PROTECTION DECISIONS INVOLVE RISK

- Deciding if a child is in need of protection
- Determining if a child can remain at home or should be apprehended
- Should service be provided on a voluntary or court ordered basis
- Which cases or situations should be given priority, the most time and resources
- Should a parent have access or supervised access to a child removed because of abuse or neglect
- When is it safe to re-unite children and families
- Can a case be safely closed

4. INADEQUACY OF THE HISTORICAL APPROACH TO RISK ASSESSMENT

- Largely an informal approach
- Poorly defined guidelines for making decisions
- Primarily left to the individual approach and experience of each child protection worker
- Subjective process open to personal bias
- Vulnerability of individual workers to liability for risk decisions

CURRENT DEVELOPMENTS IN RISK ASSESSMENT RESEARCH AND PRACTICE

As a result of the need to improve risk assessment and risk management practice considerable research and development has taken place. A variety of approaches and modules have been identified and some significant research undertaken to improve the validity and reliability of risk assessment instruments.

THE RISK ASSESSMENT VERSUS THE RISK MANAGEMENT APPROACH

Overall, the child welfare field is moving rapidly towards incorporating a more formalized, structured approach to risk assessment and decision making. Two different responses have emerged. The risk assessment and the risk management approach. The risk assessment approach involves the use of a specific risk assessment instrument to help measure the level of risk to a child, while it attempts to develop a system of managing risk throughout the life of a case and thus include the use of a risk assessment instrument.

In the United States, over forty states have implemented a risk assessment instrument. About one-half of these states have also introduced a risk management system. In Canada, *most of the* provinces have recently implemented risk management systems.

A wide variety of risk assessment instruments or tools have been developed. These vary in their depth, comprehensiveness, usefulness and the degree to which they are based on current child abuse knowledge and research. Some instruments attempt to measure family functioning, child well being or parental capacity. Strictly speaking, these tools do not specifically assess the risk of abuse or neglect towards a child. On the other hand, a risk assessment instrument focuses primarily on risk and does not attempt to provide a comprehensive assessment of the child and family.

RESEARCH DEVELOPMENTS

Research related to risk assessment is a relatively new development. So there is much that is not known and much work to be done to validate empirically the instruments being used to assess risk. Generally, there is agreement that well designed, researched and implemented risk assessment instruments have:

- Inter-rater reliability (different users can get the same results)
- Content validity for individual factors (each factor by itself has validity)

Research has yet to demonstrate that risk assessment instruments have predictive validity (can predict with certainty the likelihood of re-abuse or the severity of any re-abuse)

At the present time, most risk assessment instruments do not provide a numerical score or predictability percentage. They assess risk along a continuum of no risk to high risk.

HOW THE NEW BRUNSWICK MODEL WAS DEVELOPED

The New Brunswick risk management model has been developed through the efforts of a working group with broad Department representation. The working group developed several principles, which guided their activities and the development of the risk management model:

- Risk assessment is an on-going process throughout the life of a child protection case
- Formalized, structures risk assessment helps to improve but does not replace professional judgement
- Risk assessment should be child centered
- The model should be clear, make sense to and be usable by front-line staff
- The model should have credibility and validity

In developing the risk management model, the first working group reviewed:

- The major risk assessment literature and research
- The strengths and weaknesses of current Canadian and US risk assessment models

Based on this review, a risk management approach was recommended and developed. The New York State Department of Social Services safety assessment and risk assessment instruments were chosen as best meeting the requirements outlined in the guiding principles. These instruments were then adapted for use by the Department.

Following recommendations submitted in July 1998, by the Child Death Review Committee, a working group was established to revise the risk management system. The mandate was to modify our New Brunswick model to better reflect the areas of neglect, by adding further neglect elements to the Risk Assessment Tool.

THE NEW BRUNSWICK RISK MANAGEMENT MODEL

THE KEY COMPONENTS OF THE MODEL

- 9 RISK DECISION POINTS
- CRITERIA TO GUIDE EACH DECISION
- DOCUMENTATION OF EACH DECISION
- AN IMMEDIATE SAFETY ASSESSMENT AND SAFETY PLAN
- COMPREHENSIVE RISK ASSESSMENT INSTRUMENT
- A SERVICE PLAN CONNECTED TO THE RISK ASSESSMENT

THE NINE (9) RISK DECISION POINTS

- Risk Decision # 1: To investigate or not to investigate
- Risk Decision # 2: Immediacy of response
- Risk Decision # 3: Immediate safety assessment
- Risk Decision # 4: Verification of the report and case opening
- Risk Decision # 5: Assessment of risk
- Risk Decision # 6: Determining the level of service
- Risk Decision # 7: Re-assessment of risk
- Risk Decision # 8: Should the child be re-united with the caregiver
- Risk Decision # 9: To close or not to close the case

THE PURPOSE OF THE RISK MANAGEMENT MODEL

The risk management model is designed to help provide greater protection to children at risk of abuse and neglect by improving the quality of risk assessment and decision making.

The objectives of the risk management model are:

- To reduce the re-occurrence of abuse and neglect
- To ensure each risk decision is given careful consideration
- To provide a structured approach to risk assessment and decision making
- To provide support to front-line staff making risk decisions
- To increase client involvement in the risk assessment and service planning process
- To link case plans directly to the reduction of identified risk factors
- To increase interdisciplinary and community consensus regarding which children are considered as "high risk"
- To ensure clearer documentation, justification and credibility regarding major risk

DEFINITIONS

Risk
Risk involves the probability of the occurrence of a negative or harmful outcome.

Risk Management
Risk management is a formalized system for identifying, assessing, responding to, and documenting the risk of abuse and neglect throughout the life of a child protection case. It is a broader concept than risk assessment.

An effective risk management system:
- Identifies the key risk decision points
- Establishes who is to be involved in each decision
- Establishes the decision making process for each decision
- Identifies the criteria or risk assessment tools to be used in making each of the key risk decisions
- Requires an intervention plan to reduce identified risks
- Provides direction regarding how each decision is to be documented

Safety Assessment
The safety assessment involves a determination of the child's present safety.

Risk Assessment
Risk assessment involves an educated prediction about the likelihood of a child being abused or neglected.

Case Plan
The identification of the clients needs/problems which are to be addressed and the services to be provided to meet these needs.

The Connection Between Case Management and Risk Management

Risk assessment and risk management are part of the case management system. Risk assessment and risk management have limited effectiveness unless they are embedded in a sound case management approach. The following flow chart identifies the Department's case management system and how the risk management model is integrated into this system.

TABLE - CP CASE MANAGEMENT SCHEDULE

STEP	DECISION	PRIORITY	DEADLINES/FREQUENCY OF MEETINGS
Intake	1. To determine if an investigation is necessary (assign file)	1	Immediately
		2	Immediately
		3	Within 24 hours
		4	Within 2 working days
Investigation	2. To determine the immediacy of response (being the investigation and assign the file) 3. To evaluate the child's immediate safety	1	Immediately
		2	Within 24 hours
		3	Within 4 working days (that is a total of 5 working days from the time of receipt of the referral)
		4	Within 8 working days (that is a total of 10 working days from the time of receipt of the referral)
	4. To verify and validate the referral	1,2,3,4	Within 30 working days from the date the file was assigned to a worker for investigation
	5. To evaluate the risk Factors (Risk Assessment Tool)	1,2,3,4	Within 30 working days from the date the file is assigned to a worker for investigation (occurs once the investigation is terminated and the referral proves to be accurate or the social worker still believes the child may be at risk in the future)

STEP	DECISION	PRIORITY	DEADLINES/FREQUENCY OF MEETINGS
ONGOING SERVICE	6. To determine the level of services required	First face to face contact	5 days from the date the case is open
		Additional face to face contacts	**High Risk:** 0-3 months* (every 2 weeks) 3 months and more* (every 3 weeks) **Medium Risk:** 0-3 months* (every 3 weeks) +3 months* (every 4 weeks) **Low Risk:** 0-3 months*(every 4 weeks) +3 months (every 6 weeks) *means from the date a case is opened
		Partner's contacts	High and Medium risk: every 4 weeks Low risk: every 6 weeks
CASE PLAN		1st plan	Within 20 working days from the date the case is open
		Revision	Every 3 months
	7. To reassess the risks	High Risk	3 - 6 months
		Medium Risk	6 - 9 months
		Low Risk	9 - 12 months
	8. To reunite the child and family or other significant events		
	9. Termination of services		

Note: For decisions #7, #8 and #9 Risk Assessment Instrument must be utilized.
In the standards we refer to **working days** instead of **calendar days.**

MODULE II

RISK DECISION # 1
TO INVESTIGATE OR
NOT TO INVESTIGATE

MODULE II
RISK DECISION # 1:
TO INVESTIGATE OR NOT TO INVESTIGATE

Commentary

This decision determines if the report of a child whose security or development may be in danger is accepted for investigation. It is a critical "gate-keeping" decision which either opens or closes the door to child protection services. The quality of this decision is dependent on the sufficiency and accuracy of information obtained during the intake process from the referral source, and other key informants, and relevant record checks.

Refer To Child Protection Services Standards Section...3.2.

Procedures

The initial response to reports of children in need of protection involves several distinct but related steps.

1. Receiving the Report

Reports of children in need of protection may come from several sources: the child, family members, the public, or community professionals. The identity of the reporter may be declared or the reporter may wish to be anonymous. The motivation prompting the report may range from observation of possible abuse to well-meaning but vague concerns for a child's welfare, to malicious allegations. Child protective services cannot control the nature of the motivation underlying the referrals. So child protection services must screen each report carefully and consistently to determine the need for investigation and protective services. This is no easy task. Frequently the nature of the report or the reporter's motivation is unclear. Sometimes a high level of emotionality surrounds the report. These characteristics render decision-making difficult. At the same time decisions must be made quickly, often immediately, regarding a child's need for protective services.

The manner in which the report is received is an important step in the intake process, and one which directly affects the decisions which have to be made. Some approaches found to be helpful in receiving reports/referrals are:

- start from and maintain a position of concerned objectivity
- take notes as soon as the reporter begins speaking
- Respond to the reporter in ways which reduce defensiveness
- listen carefully to the reporter's statement of concern
- obtain as much information as necessary to determine the credibility of the report, the credibility of the reporter, and the urgency of the response required
- advise the reporter what will happen next

2. Obtaining Thorough Information From the Reporter

It is important to obtain as much relevant information as possible from the reporter. More complete information and understanding promotes more accurate decision-making.

Where possible detailed information should be obtain regarding four critical areas:

A. The circumstances/situation which prompted the report

- what caused the report to be made?
- the sources of the reporter's information, e.g. own observations, something someone else told the reporter
- details regarding the reporter's concern or incident which precipitated the referral

what was seen by whom?	when it took place?
what was heard by whom?	who did what?
who was present?	what were the consequences or harm/neglect?
where it took place?	the condition of the child?
what happened next?	

- exploration of any opinion presented by the reporter, e.g. the child appeared fearful. Ask for specific information regarding the basis of the opinion. For example, what did the reporter see or hear which helped to form this opinion.
- does the reporter have knowledge of other relevant incidents?
- is the child/family aware of the report?
- any actions taken by the reporter?

B. The children at risk

- names, ages, sex of children
- address and current whereabouts
- present physical/emotional condition
- any specific vulnerabilities including disabilities and medical condition
- any special communication issues
- school/day care attended
- is this an aboriginal child and if so to what band or community odes the child belong
- religion/cultural considerations

C. The child family/the alleged abuser

- parent's names, addresses, telephone numbers, whereabouts, work place
- alleged abuser's name, address, telephone number
- current whereabouts of the alleged abuser and access to children
- any special concerns regarding the mental health, physical illness, violence or substance abuse by the alleged abuser or family member
- relationship of the alleged abuser with the child
- parental awareness/admission/reaction to the situation
- communication/cultural considerations
- family physician

D. Other witnesses/sources of information

- who else has direct knowledge of the incident/concerns reported?
- who else might have observed the child's condition or other incidents?
- who else knows the child/family well?
- what other professionals/agencies may be involved with the family?

3. Assessing The Reporter's Motivation/Credibility

In addition to information about the child's need for protection there is a need to obtain information regarding the reporter's motivation.

Most reports of child abuse are based on genuine and valid concerns about children. Sometimes the reporter's motivation may be well-meaning but based on vague allegations or parent's life style issues. These reports usually contain insufficient evidence to justify an investigation, or reflect differences in values or beliefs which are not subject to child protection intervention. On occasion the reporter's motivation may be suspect. Experience has shown that the more positive the reporter's motivation for reporting, the greater the validity there is likely to be to the report.

It is possible for valid reports to occur even when there is a concern regarding the reporter's motivation. For example, a valid report may be made within the context of a custody/access dispute, or even by someone who has been drinking. Reports involving questionable motivation or incapacity of the reporter must be thoroughly evaluated before determining their validity.

The following questions may help to provide information which can be used to assess the reporter's motivation. The response to these questions need to be considered along with the quality and reliability of the detailed information provided regarding A, B, C,D above.

- what is the reporter's relationship to the child/family?
- how long has the reporter known the child/family?
- reasons for wanting to remain anonymous
- if there was a delay in reporting, what was the reason for reporting now?

- if the reporter knew of previous incidents what was the reason they were not reported?
- has the reporter made other referrals and if so were they accurate/valid?
- is the reporter willing to meet fact to face to discuss their concerns?
- is the reporter focused on the best interests of the child?
- are there any indication, in a case reported by a professional, that the referral involves "dumping", that is, inappropriately referring the case because of frustration or anger at the client?

4. Initial Record Check

Determine if there has been prior involvement and specify nature of such.

5. Determining if the report should be accepted for investigation

Determining if a report should be investigated is an important risk decision. An erroneous decision may leave a child unprotected. Alternatively, an erroneous decision may cause a family's privacy to be invaded without sufficient cause, and may commit scarce staff resources to a time-consuming but unnecessary investigation process. The decision needs to be made using identified objective criteria and with supervisory consultation.

The Decision Criteria

In making Risk Decision # 1: to investigate or not to investigate the following criteria should utilized:

General Criteria

The report should be investigated if there are any doubts regarding:

- the child's safety and well-being
- the child's need for protection
- the ability and willingness of the child's parent/caregiver to care for and protect the child

Specific Criteria

A. JURISDICTION

1. Age of child
2. Location of child
3. Section of the Act which applies and provides authority

B. REASONABLE GROUNDS

Reasonable grounds which support one or more sub-sections of Section 31(1) of the Family Services Act based on facts or credible information from:

1. Direct observations/knowledge
2. Credible professional opinion
3. Credible referral source
4. Records

Direct Evidence

- eye witness observations of a caregiver's behavior/statement
- eye witness observations of a child's condition/circumstances
- child's description/disclosure statement
- statements made by the caregiver including admissions
- certificate(s) of criminal conviction
- observation of the child's living conditions
- results of forensic or medical testing

Support Evidence

- observation of the child's behaviour which is indicative of abuse/neglect or the need for protection
- professional opinion by a qualified professional
- assessment or psychological reports

Criteria For Not Investigating

- report does not fit definition of child whose security or development may be in danger
- report lacks credible facts or information
- report is so lacking in information that action cannot be taken
- the Department has previously assessed all of the information in the report and has taken appropriate action to address the circumstances

The Decision-Making Process

The screening social worker completes the screening of the report and documents the criteria which supports the decision to investigate or not to investigate. The supervisor reviews the documentation and recommendation regarding this risk decision, and signs the report when in agreement with the decision. It is recognized that in some cases immediate action is required and the worker may need to act on this decision prior to obtaining supervisory approval. In these circumstances the decision and recommendation will be reviewed by the supervisor retro-actively.

The Time Frame for Decision-Making

Refer to table – CP Case Management Schedule

Documenting the Decision

All referrals are to be recorded in the computerized information system.
In addition the Initial Intake Report form should be completed within 24 hours.

Instructions for Completing the Initial Intake Report

The information obtained through #2-A,B,C,D and #3 outline above is incorporated into the Initial Intake Report.

Client's Name: _____ Date: _____

Intake ID: _____

INITIAL INTAKE REPORT - CHILD PROTECTION SERVICES

DETAILS OF CHILD ABUSE/NEGLECT PROTECTION REPORT

A. Current concerns/situation

B. Current whereabouts/condition of child

C. Details of other incidents/concerns

D. Current whereabouts/condition of siblings/other children

E. Current whereabouts/situation re: parents/caregiver

2. ASSESSMENT OF THE MOTIVATION OF PERSON MAKING REPORT/REFERRAL

3. OTHER PERSONS HAVING RELEVANT INFORMATION ABOUT CHILD/FAMILY

A. Family Physician **Name:** _____ **Tel:** _____

Information Provided

B. School/Nursery/Daycare **Name:** _____ **Tel:** _____

Information Provided

C. 1 Other **Name:** _____ **Tel:** _____

Information Provided: **Agency:** _____ **Relationship to Child/Family:** _____

C. 2 Other **Name:** _____ **Tel:** _____

Information Provided: **Agency:** _____ **Relationship to Child/Family:** _____

C. 3 Other | Name: | Tel:
Information Provided: | Agency: | Relationship to Child/Family:

C. 4 Other | Name: | Tel:
Information Provided: | Agency: | Relationship to Child/Family:

4. INITIAL RECORD CHECK

Record Check	Summary of information obtained

5. INTAKE DISPOSITION: CHILD PROTECTION

A.1 Reasonable grounds to conduct child protection investigation ☐ Yes ☐ No

A.2 Specify Section of Family Services Act

B. Reasons supporting the decision

C. Priority of response

- ☐ Life Threatening
- ☐ Dangerous
- ☐ Damaging
- ☐ Potentially Damaging

D. Priority for actions (other comment and clarification

E. Intake disposition

- ☐ Closed
- ☐ Sent to investigation

Social Worker: _____ **Date:** _____

Supervisor: _____ **Date:** _____

Assigned to: **Date:**

Client's Name: _____ Date: _____

Intake ID: _____

INITIAL INTAKE REPORT - CHILD PROTECTION SERVICES

DETAILS OF CHILD ABUSE/NEGLECT PROTECTION REPORT

A. Current concerns/situation

Teacher today noticed 4 welts on the back of William's (age 9 yrs) legs. The welts were 3-4 cms long and had the outline of a strap. The welts were red in colour and the outline of strap was faint – not well defined. No other marks were noticed other than a small (dime size) bump on right side of head. Child stated didn't know how he got the marks.

B. Current whereabouts/condition of child

Child is at school until 3:45pm. Child is not in pain, is able to sit, walk without any difficulty. Medical attention not required for welts. Child appears to teacher to be apprehensive when questioned.

C. Details of incidents/concerns

Teacher has known William for 6 months.
Has not noticed any other unusual or unexplained injury.
Attendance is good. He is active, low functioning, may have developmental disability.
Seems to lack self confidence and is angry at the world.

D. Current whereabouts/condition of siblings/other children

Sister Heidi (age 6 yrs) at school.
William's teacher will check to see if Heidi's teacher has concerns about her.
Brother John (age 4 yrs) at home.

E. Current whereabouts/situation re: parents/caregiver

Mother at home
Father at home
They own a farm. The father works on the farm.
Parents have had limited contact with school, but have been cooperative.

2. ASSESSMENT OF THE MOTIVATION OF PERSON MAKING REPORT/REFERRAL

Teacher has 10 years of experience.
Teacher has known William for 6 months.
Teacher appears to have good knowledge of what's appropriate in terms of bruises and explanations.
Teacher seems concerned for child.
No sense of overreaction in this referal.

3. OTHER PERSONS HAVING RELEVANT INFORMATION ABOUT CHILD/FAMILY

A. Family Physician Name: Dr. James Tel: 444-1111

Information Provided

B. School/Nursery/Daycare Name: Tel:

Information Provided

C. 1 Other Name: Mrs. Freemont Tel: 441-1122

Information Provided: Agency: school Relationship to Child/Family: Heidi's teacher

C. 2 Other Name: Tel:

Information Provided: Agency: Relationship to Child/Family:

C. 3 Other	Name:	Tel:
Information Provided:	Agency:	Relationship to Child/Family:

C. 4 Other	Name:	Tel:
Information Provided:	Agency:	Relationship to Child/Family:

4. INITIAL RECORD CHECK

Record Check	Summary of information obtained
Department Records	No previous contact/reports re family

5. INTAKE DISPOSITION: CHILD PROTECTION

A.1 Reasonable grounds to conduct child protection investigation [x] Yes [ ] No

A.2 Specify Section of Family Services Act

Possible abuse under 31(1)(e)

B. Reasons supporting the decision

Age of child

Reasonable grounds are: credible reporter saw bruising like welts
Location and type of injury not likely accidental
Child give no explanation

C. Priority of response

- [ ] Life Threatening
- [ ] Dangerous
- [x] Damaging — Moderate physical abuse
- [ ] Potentially Damaging

D. Priority for actions (other comment and clarification)	Timing:
1. Meet with William's teacher	Before 2pm
2. Meet with Heidi's teacher	Before 2pm
3. Interview William	Before 3pm
4. Check with family doctor	This am
5. Meet parents	After 3pm

E. Intake disposition

- [ ] Closed
- [x] Sent to investigation

Social Worker: _____ Date: _____

Supervisor: _____ Date: _____

Assigned to: Date:

MODULE III

RISK DECISION #2:
IMMEDIACY OF RESPONSE

MODULE III
RISK DECISION #2:
IMMEDIACY OF RESPONSE

Commentary

Once the referral has been screened and the decision is made to investigate, it is expected that an investigation will begin as soon as possible. In urgent situations the investigation must begin immediately. In other situations a less urgent response may be appropriate. From time to time there may be situations where several reports are received in a short period of time all of which require action to be taken quickly. Where such a situation makes it impossible for all reports to be investigated immediately, a framework to guide and ensure consistent decision-making is required. This framework helps to determine the priority and immediacy of response to each referral accepted for investigation.

Refer to Child Protection Services Standards Section...4.1

The Decision Criteria

In making Risk Decision #2: The immediacy of response, the following criteria should be utilized:

General Criteria

The age, vulnerability and capacity of the child may increase the risk of harm to a child and should be considered in all cases. This may result in an upgrading of the response assigned to the situation.

Specific Criteria

DETERMINING THE IMMEDIACY OF RESPONSE

PRIORITY #1 SERIOUS AND IMMINENT DANGER (LIFE THREATENING SITUATIONS)

- Death of a child
- Severe Physical abuse
- Severe Physical Neglect
- Severe failure to thrive (non-organic)
- Life threatening medical neglect
- Child attempts or threatens suicide
- Severe lack of supervision
- Child under 12 years who kills or seriously injures someone
- Parent psychotic, behaving in a bizarre manner or threatening to seriously harm child

PRIORITY #2
DANGEROUS BUT NOT LIFE THREATENING

- Serious physical abuse
- Serious Physical Neglect
- Severe and serious sexual abuse
- Serious medical neglect
- Serious lack of supervision
- Homeless child
- Runaway or missing child
- Sudden death of parent

PRIORITY #3 DAMAGING BUT NOT LIFE THREATENING OR DANGEROUS

- Moderate physical abuse
- Moderate Physical Neglect
- Moderate sexual abuse
- Moderate medical neglect
- Serious emotional abuse
- Parents refuse treatment (non-medical) for child
- Family violence
- Child under 12 years causes significant property damage

PRIORITY #4 POTENTIALLY DAMAGING

- Likelihood of physical harm/neglect
- Likelihood of sexual abuse
- Likelihood of emotional harm

Override Notes

It is possible that the circumstance of a particular case requires that the immediacy of response be either upgraded or downgraded.

For example, the specific circumstance of a likelihood of physical harm, or likelihood of sexual abuse situation (normally a Priority #4) could be such that the immediacy of response should be identified as Priority #1, #2 or #3. Likewise the specific circumstances of a child's suicide threat (normally a Priority #1) could be such that the immediacy of response should be identified as a Priority #2, #3 or #4.

Where justification exists an override can be applied to the immediacy of response framework to ensure that the appropriate response is identified. When an override is made it should be documented in the Initial Intake Report.

DEFINITION OF PRIORITIES

The following descriptions and examples help to define the general conditions listed under each of the 4 priorities. These descriptions and examples are not meant to be all inclusive. Other conditions may be included in each priority category as appropriate.

PRIORITY #1: SERIOUS AND IMMINENT DANGER (LIFE THREATENING SITUATIONS)

Death of a child

Where the child is believed to have died from suspicious rather than accidental, medical or any other reason which does not suggest abuse/neglect by omission or commission.

The risk would be with respect to the safety of siblings, future child to be born to the abusing family, or the abuser's contact with other children.

Severe physical abuse

This would include injuries resulting from a physical assault which would usually require immediate medical attention.
Injuries in this category include:

- Head injuries with risk of central nervous system damage
- Internal injuries
- Fractures
- Multiple injuries
- Medical condition such as child in comatose state
- 2nd or 3rd degree burns

Severe physical neglect

This category includes neglect that exposes the child to life-threatening hazards, such as:

- Homes where exposed wires or drug paraphernalia are accessible to the child
- An unguarded well or balcony accessible to the child
- Dangerous weapons accessible to the child
- Potentially fatally depriving an infant of food and fluid.

Severe failure to thrive (non-organic)

This condition is most often found in children under 4 years who have been deprived of sufficient nutrition. The younger the child the greater the risk. A medical diagnosis is needed to determine organic (disease related) or non-organic causes.

Non-organic failure to thrive can be related to parental acts of either omission or commission. Severe failure to thrive is considered when the child is below the 3rd percentile for weight expected for a child of similar age and there is no medical reason for the lack of weight gain.

Life threatening medical neglect

This involves parental unwillingness or refusal to obtain required medical assistance for their child. Some examples of life threatening situations included:

- failure to consent to blood transfusion where the physician is of the opinion that the child's life will be endangered without this procedure
- failure to obtain medical care for a child who appears to be very ill
- failure to provide medication as a result of which the child's life may be endangered

Child attempts or threatens suicide

Suicide threats or attempts are usually handled by mental health, medical or police services. However, there may be some situations in which immediate child protection intervention is required:

- if a child advises the Department of a suicide attempt/threat
- if assistance is requested by other professionals
- if the parents are unwilling or unable to seek appropriate help for their child

Severe lack of supervision

Examples of situations included in this category are:

- very young child or child with a disability found wandering from home without adult or appropriate supervision
- child who appears to have been abandoned
- child under 12 years or with a disability who is left without appropriate supervision

Child under 12 years who kills or seriously injures someone

Since children under the age of 12 years cannot be charged under the Young Offenders Act, child welfare legislation provides for protective intervention for such children who may engage in criminal behaviour. Children who kill or seriously injure another person require an immediate child protection response.

Parent psychotic, behaving in a bizarre manner or threatening to seriously harm child

In this category are caregivers who may be out of touch with reality, or who are extremely volatile, or have little or no impulse control and are verbally or otherwise threatening to do harm to the child.

PRIORITY #2: DANGEROUS BUT NOT LIFE THREATENING

Serious physical abuse

This category includes physical abuse which is serious, frequent or chronic.
Possible injuries include:

- small burns or cigarette burns
- multiple lacerations, bruises, welts
- injury suggests the use of an instrument which could disfigure or result in permanent impairment
- medical attention is required, but is not a medical emergency

Serious physical neglect

This category includes physical neglect that is serious, frequent, or chronic, exposing the child to dangerous, but not life-threatening hazards such as:

- extremely filthy homes (e.g. the child is exposed to animal/human feces, garbage, rotting food or vermin).
- leaving the child in a crib or playpen for extreme lengths of time without attention or stimulation
- chronically inadequate nourishment
- inappropriate clothing in extreme climates or weather conditions

Severe and serious sexual abuse

This category involves situations where children are sexually abused by parents, relatives, other caregivers or persons in authority. It also includes children who are sexually abused as a result of a lack of supervision.

Examples of severe sexual abuse include:

- vaginal, anal or oral penetration
- use of overt force to perpetrate the abuse
- ritualistic or bizarre sexual activities e.g. sadistic sexual acts, bestiality
- where both parents are actively involved in the abuse
- where there are multiple offenders sexually abusing the child
- involvement of the child in pornography or prostitution

Examples of serious sexual abuse include:

- sexual interference e.g. fondling a child
- invitations to sexual touching e.g. where the offender manipulates, coerces the child into sexually touching them

Serious medical neglect

Serious medical neglect includes those situations where a child's parents are unwilling or unable to obtain medical or physical care for the child, resulting in physical harm, injury, suffering or impairment to the child.

Examples include:

- lack of medical care or unnecessary delay of medical treatment for an injury or serious illness
- serious lack of dental care causing suffering to the child
- lack of medical care which results in permanent damage, impairment to the child

Serious lack of supervision

This category includes acts of omission or commission by the caregiver which place children in hazardous situations.

Examples include:

- children frequently out late at night and their whereabouts are unknown to the parents or they are without appropriate supervision
- children who are left on their own for extended periods of time
- children who are not protected from serious home hazards such as stoves, wood stoves, machinery, tools, open windows in high rise buildings, etc.
- children who come and go from home as they please and appear to be without parental supervision, guidance or control

Homeless child

This category includes youth that are without a parent or guardian and have no place to live. It also includes youth who are "evicted" from their homes and for whom no alternative living arrangements have been made.

Runaway or missing child

This category includes children who are missing or who have run away from home. Where a young child is reported missing or when an older child is reported missing after a reasonable period of time e.g. did not return home on time), the situation should be reviewed as having potential danger to the child.

Where the child is known or suspected of running away the matter should be viewed as involving possible danger to the child based upon a consideration of the following:

- frequency/duration of previous episodes of running away
- length of time the child has been absent
- special needs, disabilities or vulnerabilities of the child

Sudden death of a parent

This may involve situations where the child is:

- traumatized by the nature and suddenness of the parent's death
- traumatized by witnessing the parent's death
- temporarily without supervision or guardianship because of the parent's death

PRIORITY #3: DAMAGING, BUT NOT LIFE THREATENING OR DANGEROUS

Moderate physical abuse

This category refers to situations where a child receives physical injuries which are neither life threatening or dangerous. However, the child may experience physical harm, pain or suffering which is damaging.
Examples include:

- minor bruising on the extremities of the body
- a single, but large bruise
- bruises in places near vital organs
- hand print on the face
- multiple bruising of the buttocks

Moderate physical neglect

This category related to physical neglect that could be damaging if frequent or chronic, such as:

- inattention to basic hygiene, leading to frequent infections
- inadequate or inappropriate clothing resulting in potentially damaging exposure to the elements
- poor nutrition leading to compromised growth and development
- inadequate rest and sleep resulting in diminished learning or other developmental impediments

Moderate sexual abuse

This category includes activities which are sexual in nature, but do not include penetration or touching of breast, genital or anal areas.

Examples include:

- adult exposing self to child
- making sexual suggestions to the child
- sexual kissing
- adult voyeurism regarding the child

Moderate medical neglect

Moderate medical neglect includes those situations where the child's parents fail to make arrangements for necessary medical/dental care as needed. Parents neglect to follow up on plan of medical treatment and/or medication, etc.

Serious emotional abuse

Serious emotional abuse involves situations of extreme rejection, chronic hostility or withdrawal of affection. Examples include situations where the parent has repeatedly:

- rejected the child
- deprived the child of affection or cognitive stimulation
- exposed the child to family violence or severe conflict
- given or made inappropriate criticism, threats, humiliation, accusations, or expectations of or towards the child
- terrorized the child
- isolated the child in an unreasonable manner for inappropriate periods
- corrupting the child
- repeated shuffling of a child from one household to another

Parents refuse treatment (non-medical) for child

This category includes those situations where the child has a diagnosed emotional, mental or developmental need which requires a specific remedial program, which if not applied, could result in harm or developmental impairment for the child and the parent refuse, or otherwise do not ensure treatment for the child.

Examples include:

- a child with severe emotional problems requiring residential care
- a child with a developmental disability who requires a specific program of stimulation
- a child with serious behaviour problems, e.g. fire setting, physical aggression, sexually intrusive. etc. requiring a specific therapeutic program.

Family Violence

This category refers to those situations where a child witnesses serious or repeated physical assault of the parent. In addition to the emotional damage which may result from this exposure to family violence, some children may be at risk of being physically assaulted if the abuser lacks self control, or if the children intervene to protect the parent.

Child under 12 years causes significant damage

This category refers to situations where children are under 12 years and are apparently out of the control of their parents and cause considerable property damage.

Examples include:

- a child who has vandalized extensively
- a child who has set fire to property
- a child who has stolen and damaged cars

PRIORITY #4: POTENTIALLY DAMAGING

Likelihood of physical harm/neglect

Included in this category are those situations or parental behaviors that could result in the child suffering physical harm or neglect, by omission and/or deliberate infliction.

Examples include:

- parent knowingly allowing their child to be cared for by a person convicted of previous assaults on children and/or where the department has previously concluded that a child's security and development could be a danger in the presence of such a person
- parent threatens physical harm to child
- where the parent has previously harmed a child under similar circumstances
- parent temporarily or permanently without adequate parental capacity and has no effective support system

Likelihood of sexual abuse

Included in this category are those situations or parental behaviours which could result in the child being sexually abused, either by lack of supervision or deliberate infliction.

Examples include:

- parent knowingly allowing their child to be cared for by a person convicted of previous sexual abuse of children
- lack of parental supervision which may place the child at risk of sexual abuse
- the child being present at or exposed to incidents of sexual abuse or sexual exploitation between other family members
- where the conditions which existed in the family at the time of a previous incident of sexual abuse are present again
- parent temporarily or permanently without adequate parental capacity and has no effective support system

Likelihood of emotional harm

Included in this category are those situations or parental behaviours which could result in the child being emotionally abused.

Examples include:

- unwanted child
- child who is viewed as different and treated differently
- where the conditions which existed in the family at the time of a previous incident of emotional abuse are present again
- parent temporarily or permanently without adequate parental capacity and has no effective support system

The decision making process

The screening social worker on completion of the Initial Intake Report indicates the appropriate immediacy of response based on the information received from the referral source. The supervisor reviews the immediacy of response decision when the Intake Report is submitted for review. It is recognized that in some cases immediate action is required based on the priority of response necessary to protect a child. In these circumstances the supervisor reviews and approves the Initial Intake Report documentation retro-actively.

The time frame for decision making

The immediacy of response is determined by the priority levels and at the same time as risk decision #1 is made.

Documenting the decision

Risk decision #2 is documented in the appropriate section of the Initial Intake Report.

MODULE IV

RISK DECISION #3
ASSESSING THE CHILD'S IMMEDIATE SAFETY

MODULE IV:
RISK DECISION #3:
ASSESSING THE CHILD'S IMMEDIATE SAFETY

Commentary

The decision regarding the child's immediate safety is made during the early stages of the investigation. This decision focuses on the child's current situation. The purpose is to determine whether the child is in immediate danger and to develop an immediate safety plan to protect the child. The assessment of immediate safety determines the current safety of the child and what steps are necessary to ensure safety during the investigation process. The immediate safety assessment differs from a risk assessment because it focuses on the present situation and does not attempt to predict the occurrence of further harm to the child.

Refer to Child Protection Services Standards Section...4.1

Helpful Information

The immediate safety assessment instrument should be completed when there are sufficient facts to make a decision regarding the child's need for immediate safety. This may occur at the point of referral or after the first contact with the child or family.

Immediate safety may be reassessed at any time during investigation.

THE DECISION CRITERIA

General Criteria

The age, vulnerability and capacity of the child may affect the child's current safety and should be considered in all cases.

Specific Criteria

The Immediate Safety Assessment instrument contains 14 factors, which should be assessed when determining the child's immediate safety. These represent the minimum factors, which should be considered in making this decision. Any additional factors relevant to a child's safety in a particular situation should also be included in the assessment.

Specific Criteria: Safety Factors:

1. Caregiver's behaviour is violent or out of control.
2. Caregiver describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.
3. Caregiver caused, or has made a plausible threat that has or would result in serious physical harm to the child.
4. Caregiver refuses access to the child.
5. Child's whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee.
6. Caregiver has not, or will not provide sufficient supervision to protect child from potentially serious harm.
7. Caregiver has not, or is unable to meet the child's immediate needs for food, clothing, shelter and/or medical care.
8. Caregiver has previously abused or neglected a child and the severity of the abuse or neglect, or the caregivers prior response to the incident suggests that child safety may be an immediate concern.
9. Child is fearful of people living in or frequenting the home.
10. The child's physical living conditions are hazardous and may cause serious harm.
11. Child Sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.
12. Caregiver's drug or alcohol use seriously affects his/her ability to supervise, protect, or care for the child.
13. Caregiver's emotional/health status seriously affects his/her ability to supervise, protect, or care for the child.
14. Child exhibits dangerous behaviours or behaviours which trigger violent reaction in caregiver.
15. Others.

INSTRUCTIONS FOR COMPLETING THE INITIAL SAFETY ASSESSMENT

Safety Factor Identification

Determine whether any of the listed 14 safety factors are present with respect to one or both of the caregivers or child(ren) in the family.

Determine whether any additional safety factors are present.

In determining if a safety factor is relevant consider whether the specific factor:

- recently occurred
- is present now
- is very likely to occur in the immediate future

Keep in mind the focus of the Initial Safety Assessment is the immediate safety of the child(ren). The risk of future harm or the potential for re-occurrence of abuse or neglect is assessed through the comprehensive risk assessment.

For each factor indicate by checking "yes" or "no" whether the safety factor is present or absent. Where information is lacking to make this determination on any factor check "not known".

"Caregiver" is meant to identify any person having charge of the child or exercising care and control over the child. Different safety factors may be present or absent for different caregivers. The identity of the caregiver and the child who may be unsafe as a result of caregiver behaviour, is noted in the section "Information Supporting Safety Factor".

Information Supporting Safety Factor

Where a safety factor is judged to be present it is necessary to describe briefly the facts/information/behaviours or conditions which support this judgment. This is to be done for each safety factor assessed as present. For each safety factor present provide a brief, but specific statement containing the information which was considered in deciding that the factor was present.

Include in each supporting statement the identity of the caregiver to whom the safety factor applies. The identity of the child(ren) relevant to each safety factor should also be indicated.

The Safety Decision

The child is considered to be safe when the assessment of available information concludes that the child is not in immediate danger of serious harm/neglect and no safety interventions are required. Ultimately this is a matter of professional judgement. The safety factors and supporting descriptions help to focus this judgement. The weight given to each safety factor, which is present, and to the overall assessment of safety is one of professional judgment.

The safety decision should consider the child(ren)'s present situation.

It is possible that some intervention has been initiated as a result of the incident or the child protection report. Where this intervention needs to be continued or an intervention needs to be continued to ensure safety, the situation should be assessed as "unsafe".

Where there are no safety factors present or where the circumstances which placed the child(ren) in immediate danger of serious harm/neglect have now been resolved (without an ongoing intervention) the situation should be assessed as "safe".

Safety may be an issue for one or all of the children in the family. The identity of the child(ren) considered "unsafe" should be indicated.

The Immediate Safety Plan

Where the situation has been assessed as "unsafe" document under the Initial Safety Plan the interventions which have taken place or which will be taken immediately to protect the child(ren) from immediate and serious harm/neglect.

Under "Other Interventions" identify other steps/service being taken to assist the family.

The Decision Making Process

The screening social worker on completion of the Initial Intake Report may complete the Initial Safety Assessment based on the information received from the referral source. Alternatively the investigating worker may complete this assessment early in the investigation process. Because of the importance of this decision supervisory consultation should be obtained. In exceptional situations the social worker may have to make the assessment independently and act accordingly to protect the child. In these circumstances the supervisor reviews and approves the Initial Safety Assessment and Safety Plan retro-actively.

The Time Frame for Decision-Making

The Initial Safety Assessment should be completed when sufficient facts have been gathered to make a decision regarding the child's need for immediate safety. This may occur at the point of referral or after the first contact with the child or family.

It is not necessary to wait until information on all 14 safety factors has been obtained in order to make the initial assessment of safety.

Initial safety may be re-assessed at any time during the investigation

Documenting the Decision

This initial safety decision is documented by completing the **Initial Safety Assessment instrument**.

IMMEDIATE SAFETY ASSESSMENT

Caregiver Name: _____

Child(ren): _____ Age(s): _____

SAFETY FACTOR:	PRESENT	INFORMATION / FACTS SUPPORTING SAFETY FACTOR:
1. Caregiver's behavior is violent or out of control.	Yes ☐ No ☐ Not known ☐	
2. Caregiver describes or acts towards child in predominantly negative terms or has unrealistic expectations.	Yes ☐ No ☐ Not known ☐	
3. Caregiver caused serious physical harm to the child or has made a plausible threat that would result in serious physical harm to the child.	Yes ☐ No ☐ Not known ☐	
4. Caregiver refuses access to the child or indicates that access will be refused in the future.	Yes ☐ No ☐ Not known ☐	
5. Child's whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee.	Yes ☐ No ☐ Not known ☐	
6. Caregiver has not or will not provide sufficient supervision to protect child from potentially serious harm.	Yes ☐ No ☐ Not known ☐	
7. Caregiver has not or is unable to meet the child's immediate needs for food, clothing, shelter and/or medica' ıre.	Yes ☐ No ☐ N[redacted]own ☐	

SAFETY FACTOR:	PRESENT	INFORMATION / FACTS SUPPORTING SAFETY FACTOR:
8. Caregiver has previously abused or neglected this child or any other child and the severity of the abuse/ neglect or the caregiver's response to the incident, suggests that the child's safety may be an immediate concern.	Yes ☐ No ☐ Not known ☐	
9. Child is fearful of people living in or frequenting the home.	Yes ☐ No ☐ Not known ☐	
10. The child's physical living conditions are hazardous and may cause serious harm.	Yes ☐ No ☐ Not known ☐	
11. Child Sexual Abuse is suspected and circumstances suggest that child safety may be an immediate concern.	Yes ☐ No ☐ Not known ☐	
12. Caregiver's drug or alcohol use seriously affects his/her ability to supervise, protect or care for the child.	Yes ☐ No ☐ Not known ☐	
13. Caregiver's emotional/mental or health status seriously affects his/her ability to supervise, protect or care for the child.	Yes ☐ No ☐ Not known ☐	
14. Child exhibits behaviors dangerous to self or others or behaviors which triggers violent reaction in caregiver.	Yes ☐ No ☐ Not known ☐	
15. Other (Specify):		

SAFETY DECISION

☐ **No children considered to be in immediate danger of serious harm/neglect.**

☐ **Children considered to be unsafe without immediate intervention.**

Immediate safety plan

Other interventions/actions required:

SOCIAL WORKER: _____ **DATE:** _____

SUPERVISOR: _____ **DATE:** _____

IMMEDIATE SAFETY ASSESSMENT

Caregiver Name: Cadeaux, Pierre
Child(ren): Marcel
Age(s): 1

SAFETY FACTOR:	PRESENT	INFORMATION / FACTS SUPPORTING SAFETY FACTOR:
1. Caregiver's behavior is violent or out of control.	Yes ☐ No ■ Not known ☐	
2. Caregiver describes or acts towards child in predominantly negative terms or has unrealistic expectations.	Yes ■ No ☐ Not known ☐	Mother thinks baby does not like her at times Mother says baby should stop crying when she tells him He keeps doing it for attention
3. Caregiver caused serious physical harm to the child or has made a plausible threat that would result in serious physical harm to the child.	Yes ☐ No ■ Not known ☐	
4. Caregiver refuses access to the child or indicates that access will be refused in the future.	Yes ■ No ☐ Not known ☐	Mother does not want social worker to return
5. Child's whereabouts cannot be ascertained and/or there is reason to believe that the family is about to flee.	Yes ☐ No ■ Not known ☐	
6. Caregiver has not or will not provide sufficient supervision to protect child from potentially serious harm.	Yes ■ No ☐ Not known ☐	Left in closed room and can't be heard while radio turned up loud This happens 2-3 times/week for 1-2 hours at a time
7. Caregiver has not or is unable to meet the child's immediate needs for food, clothing, shelter and/or medical care.	Yes ■ No ☐ Not known ☐	Child has food withheld as punishment and weight gain is slow but not at failure to thrive level. Child has not had immunization or follow-up since birth. Diaper rash not being treated.

SAFETY FACTOR:	PRESENT	INFORMATION / FACTS SUPPORTING SAFETY FACTOR:
8. Caregiver has previously abused or neglected this child or any other child and the severity of the abuse/ neglect or the caregiver's response to the incident, suggests that the child's safety may be an immediate concern.	Yes ■ No ☐ Not known ☐	Mother experienced neglect and poor supervision as a child. She was admitted to care temp because of this. She sees nothing wrong with the way she is caring for or reacting to child -Wishes no assistance
9. Child is fearful of people living in or frequenting the home.	Yes ☐ No ■ Not known ☐	
10. The child's physical living conditions are hazardous and may cause serious harm.	Yes ☐ No ■ Not known ☐	
11. Child Sexual Abuse is suspected and circumstances suggest that child safety may be an immediate concern.	Yes ☐ No ■ Not known ☐	
12. Caregiver's drug or alcohol use seriously affects his/her ability to supervise, protect or care for the child.	Yes ☐ No ■ Not known ☐	
13. Caregiver's emotional/mental or health status seriously affects his/her ability to supervise, protect or care for the child.	Yes ■ No ☐ Not known ☐	Mother is 18 yrs old living on her own and seems emotionally immature and overwhelmed by demands of child. She does not appear to understand child's needs and responds to these like an angry child.
14. Child exhibits behaviors dangerous to self or others or behaviors which triggers violent reaction in caregiver.	Yes ■ No ☐ Not known ☐	Child cries frequently for long periods to which mother responds by taking food and toys away and putting child in crib in bedroom. She shuts the door and turns up the radio.
15. Other (Specify):		

SAFETY DECISION

☐	**No children considered to be in immediate danger of serious harm/neglect.**
☒	**Children considered to be unsafe without immediate intervention.**

Immediate safety plan

1. **Arrange for maternal grandmother to help out each day re: feeding/caring for child**
2. **Public Health visit weekly to see and weigh child**
3. **Visit mother in 2 weeks to re-assess**

If mother disagrees with plan and cannot suggest an alternative plan to ensure child's care and protection. Legal intervention to be considered.

Other interventions/actions required:

Refer to family doctor for medical examination

SOCIAL WORKER: _____ **DATE:** _____

SUPERVISOR: _____ **DATE:** _____

MODULE V

RISK DECISION #4:
VERIFICATION OF THE REPORT AND CASE OPENING

MODULE V
RISK DECISION #4:
VERIFICATION OF THE REPORT
AND CASE OPENING

Commentary

Verification or substantiation of the report that a child's security or development may be threatened is determined at the conclusion of the investigation. Verification involves a careful examination of all of the information obtained during the investigation and a decision that on the balance of probabilities it is more likely than not that abuse has occurred or that the child is in need of protection under Section 31(1) of the Family Services Act. Verification focuses on whether or not the facts/evidence gathered substantiates the child protection report. The verification process does not estimate the risk of future harm. This is a crucial risk decision because it determines whether or not there are grounds for ongoing child protection services to be provided to the child and family.

Refer to Child Protection Services Standards Sections...4.2 & 4.3

THE DECISION CRITERIA

General Criteria

1. The verification decision is based on the evidence gathered during the investigation.

2. The verification decision is made on the basis of the balance of probability. That is the evidence indicates it is more likely than not that abuse has occurred or that the child is in need of protection under Section 31(1) of the Family Services Act.

Specific Criteria

The specific factors to be considered in the verification process are:

- the validity of any statement made by the child who is the subject of the report
- the validity of any statement by a child who is a witness
- any statements made by the alleged abuser, the parents or other caregiver
- forensic or scientific evidence, e.g. blood tests, DNA tests
- physical evidence, e.g. clothing, instrument, shelter, food
- medical evidence
- personal observations of witnesses, e.g. observations of acts, behaviours conditions, statements
- certificates of criminal evidence
- corroborative evidence, e.g. not witnessing an act but confirming a child's subsequent condition, or confirming a time or location
- opinion evidence from a qualified professional, e.g. psychologist's assessment that a child's behaviour is consistent with those of an abused child, or that a specific injury required a certain degree of force

THE DECISION MAKING PROCESS

The verification process should involve the following steps:

1. A formal meeting or case conference involving as a minimum the social worker and supervisor

2. A review of all of the relevant information obtained from the investigation

3. a) An identification of all of the facts obtained in the investigation which indicate that abuse/neglect has occurred or that the child is in need of protection under Section 31(1) of the Family Services Act

   b) An identification of all opinion evidence and its credibility, which support the allegations made in the report

   c) An identification of all corroborative evidence and its strength, which support the allegations made in the report

   d) An identification of the section(s) of the Act to which this evidence applies

4. a) An identification of all of the facts that refute the allegations contained in the report

   b) An identification of all opinion evidence and its credibility which refute the allegations made in the report

   c) An identification of all corroborative evidence and its strength, which refute the allegations made in the report

5. An application of the balance of probabilities test

There are four possible outcome decisions:

- **The report is not verified and child abuse/neglect does not appear to exist**
  Under this disposition the family may request or be offered/referred to further outside services.

- **The report is verified, but the child is not in need of protection and the child remains in the home**
  This disposition generally involves third party abuse situations where there is no concern regarding the parents ability or willingness to protect the child. However, the family may request or be referred to further outside services.

- **The report is verified and the child remains in the home, but may be in need of protection**
  This decision may be appropriate in situations where the alleged abuser has been removed from the home or where the circumstances suggest the risk to the child may be low. Under this disposition a plan to ensure the child's ongoing safety may be required.

- **The report is verified and the child is removed from the home**
  The removal of the child is usually done through means of an apprehension and Court Order.

DOCUMENTING THE DECISION

The verification decision should be documented in the case file and must include summary of facts, discussion, people present decision made and date of decision. We could use the form titled "Verification Decision".

VERIFICATION DECISION

Name of family:

Summary of facts, discussions, options:

Decisions reached/services recommended:

Social worker: _____ **Date:** _____

Supervisor: _____ **Date:** _____

MODULE VI

RISK DECISION #5:
ASSESSMENT OF THE RISK OF FUTURE HARM/NEGLECT TO THE CHILD

MODULE VI
RISK DECISION #5:
ASSESSMENT OF THE RISK OF FUTURE HARM/NEGLECT TO THE CHILD

Commentary

The assessment of risk of subsequent harm/neglect is an estimation of the probability that a child will be re-abused/neglected or harmed in the future. Risk assessment is based on reviewing the major child, family, interpersonal and social factors, which are known to be associated with child abuse/neglect and establishing the degree to which these factors are present in an individual child protection case. This assessment process requires that a significant amount of information be obtained before an estimation of risk can be made. Consequently, a comprehensive risk assessment is usually conducted toward the end of the investigation stage and before a case is opened for on-going child protective services. Although the first comprehensive risk assessment is conducted at the stage of intervention, risk assessment is an ongoing process. Re-assessment of risk is required periodically and at critical points throughout the time a child protection case remains open for service.

The Rationale For Using Risk Assessment Instruments

The use of risk assessment frameworks or instruments to help assess risk are becoming standard practice in many child welfare systems. The reason for using such instruments include:

- they can improve clinical judgment and decision making by consistently focusing on key factors associated with the reoccurrence of abuse/neglect
- they can help to limit errors in judgment
- they can help to rank cases along a continuum of risk from "no risk" to "high risk"
- they can help to evaluate a child's further safety in a consistent, objective and comprehensive manner
- they can help to decrease the influence of idiosyncratic variables in decision making
- they can help to facilitate a rehabilitative approach by linking services to identified areas of risk
- they can help to guide intervention and the efficient allocation of resources
- they can provide a "common language" and can help build collateral/community consensus regarding risk

Limitations In Using Risk Assessment Instruments

All current risk assessment instruments have several limitations. These limitations need to be kept in mind when using such instruments. Major limitations include;

- current risk assessment instruments cannot predict with certainly, numerically or with great accuracy the risk of future harm/neglect to a child
- risk assessment instruments do not provide a comprehensive assessment of family functioning or the overall treatment needs of a child/family
- risk assessment instruments can help focus professional judgment, but cannot substitute for sound professional judgment, trained staff or competent supervision
- current risk assessment instruments are not adjusted to take into account cultural considerations
- no one instrument can be used to accurately assess risk in every case, so additional specialized assessment may be required to supplement the basic risk assessment
- risk assessment is most effective when it is conducted in a supportive environment, within an overall case management system and within a framework of clear policies and procedures.

Potential Sources of Error in Conducting A Risk Assessment

Several factors can lead to an inadequate or inaccurate risk assessment.
These include:

- **Inadequate training**
  - re: child protection
  - re: risk assessment
- **Over Reliance on Mechanical Tools**
- **Short Circuiting**
  - Inadequate data
  - Premature judgment
- **Biased Data**
  - Lack of necessary information
  - Dramatization of information
  - Confirming information
- **Lack of Consultation**

- **Over Confidence**
  - re: our ability
  - re: ability to predict
- **Failure to Consider Strengths**
- **Failure to Review Cultural Considerations**
- **Improper and Inappropriate Use of a Risk Assessment Instrument**
  - Improper care
  - Improper decision point

Refer to Child Protection Services Standards Section...4.4

The Decision Criteria

The New York risk assessment instrument has four components which together form the risk assessment framework and criteria.

A. FIVE INFLUENCES (Assessment Categories)

The risk assessment instrument identifies 5 major influences which are believed to contribute to child maltreatment.

- CAREGIVER INFLUENCE
- CHILD INFLUENCE
- FAMILY INFLUENCE
- INTERVENTION INFLUENCE
- ABUSE/NEGLECT INFLUENCE

B. TWENTY-TWO RISK FACTORS

A number of risk factors, which are related to each of the 5 influences, have been identified. Information regarding each risk factor sought during the assessment process. There are a total of 22 risk factors.

FOR EXAMPLE, WITHIN THE CAREGIVER INFLUENCE THERE ARE SIX RISK FACTORS:

- Abuse/Neglect of Caregiver
- Alcohol or Drug Use
- Caregiver's Expectations of Child
- Caregiver's acceptance of Child
- Physical Capacity to Care for Child
- Mental Capacity to Care for Child

C. RATING SYSTEM FOR EACH RISK FACTOR

Each risk factor is assessed on a five point scale ranging from 0 - 4, with 0 representing no risk and 4 representing high risk.

D. DESCRIPTIONS FOR RATING EACH RISK FACTOR

Descriptions are presented which provide the standard for assigning a rating from 0 - 4 for each of the 22 risk factors.

INSTRUCTIONS FOR COMPLETING THE RISK ASSESSMENT

General Considerations

1. Complete the rating for each risk factor ONLY when sufficient information has been obtained to provide a basis for making a reasonable judgment regarding the risk factor.

2. The risk assessment should be completed using the most current information available.

3. Where services are being provided at the time of the risk assessment, assign the rating which would apply to each risk factor <u>if services were withdrawn</u>.

4. Where the family is not intact, but intends to re-unite, for example, the child is in a residential placement or the parent is temporarily separated from the family, complete the rating <u>as if the family was intact at the time of the assessment.</u>

Assigning a Rating to Each of the Risk Elements

Use the description, which most closely reflects your assessment of each risk factor. An exact "fit" seldom occurs. Not all parts of the description need to be present to assign the rating to the risk element being considered. Portions of two different descriptions may apply to the risk element. Where this occurs choose the description which fits most closely. If in doubt assign the higher risk rating.

Completing the Summary Description for each Influence

After assigning a rating to each risk factor for an area of influence complete a narrative summarizing the findings regarding this influence. Describe in the summary the most significant risk factors and how they relate/interact with each other. Provide specific examples to justify your high risk ratings. Explain any circumstances in which different caregivers may have different levels of risk associated with a particular risk factor. Indicate any strengths which might mitigate any high risk findings.

The Decision Making Process

The comprehensive risk assessment is a critical component of child protection services. It determines the level of future risk to a child and this in turn forms the basis for deciding how the child can be protected. An inaccurate risk assessment can place a child in jeopardy. So this assessment must be conducted in consultation with the supervisor.

The Time Frame for Decision Making

The risk assessment should be conducted at the end of or immediately following the investigation stage. The risk assessment should be conducted prior to opening a case for ongoing child protective services, or within a short period of time after a case has been opened for protective services.

Documenting the Decision

The completion of the risk assessment instrument fulfills the risk assessment documentation requirements.

RISK ASSESSMENT

☐ Initial ☐ Review ☐ Reunification ☐ Case Closure

Client Name: _____ Children: _____ Age: _____

Male: _____ Female: _____ Other caregiver: _____

CAREGIVER INFLUENCE

CG.1 Abuse/Neglect of Caregiver

Male	Female	Other	
☐	☐	☐	4. Severe abuse/neglect as a child
☐	☐	☐	3. Recurrent but not severe abuse/neglect as a child
☐	☐	☐	2. Episodes of abuse/neglect as a child
☐	☐	☐	1. Perceived abuse/neglect as a child with no specific incidents
☐	☐	☐	0. No perceived abuse/neglect as a child
☐	☐	☐	9. Insufficient information available

CG.2 Alcohol or Drug Abuse

Male	Female	Other	
☐	☐	☐	4. Substance use with severe social/behavioral consequences
☐	☐	☐	3. Substance use with serious social/behavioral consequences
☐	☐	☐	2. Occasional substance use with negative effects on behavior
☐	☐	☐	1. Occasional substance abuse
☐	☐	☐	0. No misuse of alcohol or use of drugs
☐	☐	☐	9. Insufficient information available

CG.3 Caregiver Expectations of Child

Male	Female	Other	
☐	☐	☐	4. Unrealistic expectations with violent punishment
☐	☐	☐	3. Unrealistic expectations with angry conflicts
☐	☐	☐	2. Inconsistent expectations leading to confusion
☐	☐	☐	1. Realistic expectations with minimal support
☐	☐	☐	0. Realistic expectations with strong support
☐	☐	☐	9. Insufficient information available

CG.4 Caregiver Acceptance of Child

Male	Female	Other	
☐	☐	☐	4. Rejects and is hostile to child
☐	☐	☐	3. Disapproves and resents child
☐	☐	☐	2. Indifferent and aloof to child
☐	☐	☐	1. Limited acceptance of child
☐	☐	☐	0. Very accepting of child
☐	☐	☐	9. Insufficient information available

CG.5 Physical Capacity to Care for Child

Male	Female	Other	
☐	☐	☐	4. Incapacitated due to chronic illness or disability resulting in inability to care for child
☐	☐	☐	3. Physical impairment or illness which seriously impairs child caring capacity
☐	☐	☐	2. Moderate physical inpairment or illness resulting in only limited impact on child caring capacity
☐	☐	☐	1. Very limited physical impairment or illness with virtually no impact on child caring capacity
☐	☐	☐	0. Healthy with no identifiable risks to child caring capacity
☐	☐	☐	9. Insufficient information available

CG.6 Mental Capacity to Care for Child

Male	Female	Other	
☐	☐	☐	4. Incapacitated due to mental/emotional disturbance or developmental disability resulting in an inability to care for child
☐	☐	☐	3. Serious mental/emotional disturbance or developmental disability which seriously impairs child caring capacity
☐	☐	☐	2. Moderate mental/emotional disturbance or developmental disability with limited impairment of child caring capacity
☐	☐	☐	1. Symptoms of mental/emotional disturbance or developmental disability with no impact on child caring capacity
☐	☐	☐	0. No identifiable mental/emotional disturbance
☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Caregiver Influence. Use specific examples to justify your risk ratings. Explain circumstances in which different caregivers of children may have different levels of risk associated with particular risk element.

RISK ASSESSMENT

Child A: _____ **Child C:** _____

Child B: _____ **Child D:** _____

CHILD INFLUENCE

C 1. Child's Vulnerability

A	B	C	D	
☐	☐	☐	☐	4. Child younger than two(2) years old or older child with special needs
☐	☐	☐	☐	3. Child older than two(2) years old, not regularly accessible to community oversight
☐	☐	☐	☐	2. Child is under twelve (12) years old, attends school, day care or Childhood Development Program
☐	☐	☐	☐	1. Child is over twelve (12) years old and younger than sixteen(16) yrs old
☐	☐	☐	☐	0. Child is sixteen(16) years old or older, with adequate self-sufficiency skills

C 2. Child's Response to Caregiver

A	B	C	D	
☐	☐	☐	☐	4. Extremely anxious with uncontrolled fear, withdrawal or passivity
☐	☐	☐	☐	3. Very anxious with negative, disruptive and possibly violent interaction
☐	☐	☐	☐	2. Moderately anxious with apprehension and suspicion toward caregiver
☐	☐	☐	☐	1. Marginally anxious with some hesitancy toward caregiver
☐	☐	☐	☐	0. Child trusts and responds to caregiver in age-appropriate way
☐	☐	☐	☐	9. Insufficient information available

C 3. Child's Behavior

A	B	C	D	
☐	☐	☐	☐	4. Dangerous behavior problems
☐	☐	☐	☐	3. Serious behavior problems
☐	☐	☐	☐	2. Moderate behavior problems
☐	☐	☐	☐	1. Minor behavior problems
☐	☐	☐	☐	0. No significant behavior problems
☐	☐	☐	☐	9. Insufficient information available

C 4. Child's Mental Health and Emotional Development

A	B	C	D	
☐	☐	☐	☐	4. Incapacitated due to mental/emotional disturbance or developmental delay and unable to function independently
☐	☐	☐	☐	3. Serious mental/emotional disturbance or developmental delay impair ability to function in most daily activities
☐	☐	☐	☐	2. Moderate mental/emotional disturbance or developmental delay impairs ability to perform some daily activities
☐	☐	☐	☐	1. Symptoms of mental/emotional disturbance or developmental delay with minimum impact on daily activities.
☐	☐	☐	☐	0. No identifiable mental/emotional disturbance or developmental delay
☐	☐	☐	☐	9. Insufficient information available

C 5. Child's Physical Health and Development

A	B	C	D	
☐	☐	☐	☐	4. Severe physical illness, disability or lack of physical development; requires medical care
☐	☐	☐	☐	3. Serious physical illness, disability or lack of physical development; restricts activities without special care
☐	☐	☐	☐	2. Moderate physical illness, disability or lack of physical development; restricts activities somewhat, but overcome with special care
☐	☐	☐	☐	1. Mild physical illness, disability or lack of physical development, does not restrict activities
☐	☐	☐	☐	0. Healthy and no obvious physical illness, disability or lack of physical development
☐	☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Child Influence. Use specific examples to justify your risk ratings Explain circumstances in which different caregivers or children may have different levels of risk associated with particular risk element.

RISK ASSESSMENT

FAMILY INFLUENCE

F 1 Domestic Violence

Male	Female	Other	
☐	☐	☐	4. Repeated or serious physical violence or substantial risk of serious physical violence in the household
☐	☐	☐	3. Incidents of physical violence in household; imbalance of power and control
☐	☐	☐	2. Isolation and intimidation, threats of harm
☐	☐	☐	1. Verbal aggression
☐	☐	☐	0. No domestic violence
☐	☐	☐	9. Insufficient information available

F 2 Ability to Cope with Stress

Male	Female	Other	
☐	☐	☐	4. Chronic crisis with limited coping
☐	☐	☐	3. Prolonged crisis strains coping skills
☐	☐	☐	2. Stabilized after period of crisis
☐	☐	☐	1. Resolution without adverse effect
☐	☐	☐	0. Free from stress influence
☐	☐	☐	9. Insufficient information available

F 3 Availability of Social Supports

Male	Female	Other	
☐	☐	☐	4. Effectively isolated
☐	☐	☐	3. Some support, but unreliable
☐	☐	☐	2. Some reliable support, but limited usefulness
☐	☐	☐	1. Some reliable and useful support
☐	☐	☐	0. Multiple sources of reliable and useful support
☐	☐	☐	9. Insufficient information available

F 4 Living Conditions

Male	Female	Other	
☐	☐	☐	4. Extremely unsafe; hazardous condition(s) that is (are) dangerous to children and have (has) cause physical injury or illness
☐	☐	☐	3. Very unsafe; multiple hazardous conditions that are dangerous to children
☐	☐	☐	2. Unsafe; one hazardous condition that is dangerous to children
☐	☐	☐	1. Fairly safe; one possibly hazardous condition that may harm children
☐	☐	☐	0. Safe, no hazardous conditions apparent
☐	☐	☐	9. Insufficient information available

F 5 Family Identity and Interaction

Male	Female	Other	
☐	☐	☐	4. Negative family interactions
☐	☐	☐	3. Family interactions are generally inappropriate
☐	☐	☐	2. Inconsistent family interactions
☐	☐	☐	1. Family interactions usually positive
☐	☐	☐	0. Family interactions typically supportive
☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Family Influence. Use specific examples to justify your risk ratings. Explain circumstances in which different caregivers or children may have different levels or risk associated with particular risk element.

RISK ASSESSMENT

INTERVENTION INFLUENCE

Caregiver's Motivation

I I Male	Female	Other	
☐	☐	☐	4. No motivation to meet child's needs
☐	☐	☐	3. Very little motivation to meet child's needs
☐	☐	☐	2. Motivated to meet child's needs, but caregiver has multiple impediments to solving problems
☐	☐	☐	1. Motivated to meet child's needs, but caregiver has some impediments to solving problems
☐	☐	☐	0. Motivated to meet child's needs and caregiver has no impediment to solving problems
☐	☐	☐	9. Insufficient information available

Caregiver's Cooperation with Intervention

I I Male	Female	Other	
☐	☐	☐	4. Refuses to cooperate
☐	☐	☐	3. Cooperates minimally, but resists intervention
☐	☐	☐	2. Cooperates, but poor response to intervention
☐	☐	☐	1. Cooperates, with generally appropriate response to intervention
☐	☐	☐	0. Cooperates with intervention
☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Intervention Influence. Use specific examples to justify your risk ratings. Explain circumstances in which different caregivers or children may have different levels or risk associated with particular risk.

RISK ASSESSMENT

ABUSE/NEGLECT INFLUENCE

A 1 Access to Child by Offenders/Potential Offenders

Male	Female	Other	
☐	☐	☐	4. Open access with no adult supervision
☐	☐	☐	3. Open access with ineffective adult supervision
☐	☐	☐	2. Open access with effective adult supervision
☐	☐	☐	1. Limited access with effective adult supervision
☐	☐	☐	0. No access to child
☐	☐	☐	9. Insufficient information available

A 2 Intent and Acknowledgement of Responsibility

Male	Female	Other	
☐	☐	☐	4. Deliberate or premeditated abuse/neglect
☐	☐	☐	3. Hides or denies responsibility for abuse/neglect
☐	☐	☐	2. Rationalizes abuse/neglect or does not understand role
☐	☐	☐	1. Understands role in abuse/neglect and accepts responsibility
☐	☐	☐	0. Abuse/neglect accidental
☐	☐	☐	9. Insufficient information available

A 3 Severity of Abuse/Neglect

Male	Female	Other	
☐	☐	☐	4. Extreme harm or substantial danger of extreme harm
☐	☐	☐	3. Serious harm or substantial danger of serious harm
☐	☐	☐	2. Moderate harm or substantial danger of moderate harm
☐	☐	☐	1. Minor harm or substantial danger of minor harm

A 4 History of Abuse/Neglect Committed by Present Caretakers

Male	Female	Other	
☐	☐	☐	4. Severe or escalating pattern of past abuse/neglect
☐	☐	☐	3. Serious recent incident or a pattern of abuse/neglect
☐	☐	☐	2. Previous neglect/abuse
☐	☐	☐	1. Abuse/Neglect concerns or minor recent isolated incident
☐	☐	☐	0. No history of abuse or neglect
☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Abuse/Neglect Influence. Use specific examples to justify your risk ratings. Explain circumstances in which different caregivers or children may have different levels of risk associated with particular risk element .

RISK ANALYSIS WORKSHEET

Parent(s) Name(s): **Date:**

A. List (in point form) all factors that received a 3 or 4 rating, and any other risk factors that should be considered.

RISK ASSESSMENT ANALYSIS

A. Any additional risk factors present:

B. Describe significant family or individual strengths or other factors that have been identified that may be used as part of the case plan to reduce future risk.

C. Identify and evaluate the importance and interaction of key risk elements and describe your conclusions regarding current level of risk including reasons for your conclusions.

OVERALL RISK RATING

NAME OF CHILD:

☐ NO RISK ☐ MODERATE RISK

☐ LOW RISK ☐ HIGH RISK

Social worker's signature: _____ **Date:** _____

Supervisor's signature: _____ **Date:** _____

RISK ASSESSMENT

■ Initial ☐ Review ☐ Reunification ☐ Case Closure

Client Name: Noseworthy Children: Darren (19 mo) Kathy (12 yrs)

Male: Peter Female: Paula Other, caregiver:

CAREGIVER INFLUENCE

CG.1 Abuse/Neglect of Caregiver

Male	Female	Other	
☐	☐	☐	4. Severe abuse/neglect as a child
☐	■	☐	3. Recurrent but not severe abuse/neglect as a child
☐	☐	☐	2. Episodes of abuse/neglect as a child
☐	☐	☐	1. Perceived abuse/neglect as a child with no specific incidents
☐	☐	☐	0. No perceived abuse/neglect as a child
☐	☐	☐	9. Insufficient information available

CG.2 Alcohol or Drug Abuse

Male	Female	Other	
☐	☐	☐	4. Substance use with severe social/behavioral consequences
☐	☐	☐	3. Substance use with serious social/behavioral consequences
☐	☐	☐	2. Occasional substance use with negative effects on behavior
☐	☐	☐	1. Occasional substance abuse
☐	■	☐	0. No misuse of alcohol or use of drugs
☐	☐	☐	9. Insufficient information available

CG.3 Caregiver Expectations of Child

Male	Female	Other	
☐	☐	☐	4. Unrealistic expectations with violent punishment
☐	■	☐	3. Unrealistic expectations with angry conflicts
☐	☐	☐	2. Inconsistent expectations leading to confusion
☐	☐	☐	1. Realistic expectations with minimal support
☐	☐	☐	0. Realistic expectations with strong support
☐	☐	☐	9. Insufficient information available

CG.4 Caregiver Acceptance of Child

Male	Female	Other	
☐	☐	☐	4. Rejects and is hostile to child
☐	☐	☐	3. Disapproves and resents child
☐	■	☐	2. Indifferent and aloof to child
☐	☐	☐	1. Limited acceptance of child
☐	☐	☐	0. Very accepting of child
☐	☐	☐	9. Insufficient information available

CG.5 Physical Capacity to Care for Child

Male	Female	Other	
☐	☐	☐	4. Incapacitated due to chronic illness or disability resulting in inability to care for child
☐	☐	☐	3. Physical impairment or illness which seriously impairs child caring capacity
☐	☐	☐	2. Moderate physical impairment or illness resulting in only limited impact on child caring capacity
☐	☐	☐	1. Very limited physical impairment or illness with virtually no impact on child caring capacity
☐	■	☐	0. Healthy with no identifiable risks to child caring capacity
☐	☐	☐	9. Insufficient information available

CG.6 Mental Capacity to Care for Child

Male	Female	Other	
☐	☐	☐	4. Incapacitated due to mental/emotional disturbance or developmental disability resulting in an inability to care for child
☐	☐	☐	3. Serious mental/emotional disturbance or developmental disability which seriously impairs child caring capacity
☐	☐	☐	2. Moderate mental/emotional disturbance or developmental disability with limited impairment of child caring capacity
☐	☐	☐	1. Symptoms of mental/emotional disturbance or developmental disability with no impact on child caring capacity
☐	■	☐	0. No identifiable mental/emotional disturbance
☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Caregiver Influence. Use specific examples to justify your risk ratings. Explain circumstances in which different caregivers of children may have different levels of risk associated with particular risk element.

CG1 Parent was excessively disciplined (physical abuse for non-compliance as a child and now relies on physical punishment to control Darren.

CG3 Sees child as proscenatic and difficult expects child to eat when upset or feverish with cold, expects child to stop crying when told to.

CG4 Does not demonstrate physical affection to child. Care is "mechanical" and has little emotional connection with child. "Lack of bonding may put child at risk.

RISK ASSESSMENT

Child A: Darren (19 mo) **Child C:** _____

Child B: Kathy (2 yrs) **Child D:** _____

CHILD INFLUENCE

C 1. Child's Vulnerability

A	B	C	D	
■	☐	☐	☐	4. Child younger than two(2) years old or older child with special needs
☐	☐	☐	☐	3. Child older than two(2) years old, not regularly accessible to community oversight
☐	☐	☐	☐	2. Child is under twelve (12) years old, attends school, day care or Childhood Development Program
☐	■	☐	☐	1. Child is over twelve (12) years old and younger than sixteen(16) yrs old
☐	☐	☐	☐	0. Child is sixteen(16) years old or older, with adequate self-sufficiency skills

C 2. Child's Response to Caregiver

A	B	C	D	
☐	☐	☐	☐	4. Extremely anxious with uncontrolled fear, withdrawal or passivity
☐	☐	☐	☐	3. Very anxious with negative, disruptive and possibly violent interaction
■	☐	☐	☐	2. Moderately anxious with apprehension and suspicion toward caregiver
☐	☐	☐	☐	1. Marginally anxious with some hesitancy toward caregiver
☐	☐	☐	☐	0. Child trusts and responds to caregiver in age-appropriate way
☐	■	☐	☐	9. Insufficient information available

C 3. Child's Behavior

A	B	C	D	
☐	☐	☐	☐	4. Dangerous behavior problems
■	☐	☐	☐	3. Serious behavior problems
☐	☐	☐	☐	2. Moderate behavior problems
☐	☐	☐	☐	1. Minor behavior problems
☐	■	☐	☐	0. No significant behavior problems
☐	☐	☐	☐	9. Insufficient information available

C 4. Child's Mental Health and Emotional Development

A	B	C	D	
☐	☐	☐	☐	4. Incapacitated due to mental/emotional disturbance or developmental delay and unable to function independently
☐	☐	☐	☐	3. Serious mental/emotional disturbance or developmental delay impair ability to function in most daily activities
☐	☐	☐	☐	2. Moderate mental/emotional disturbance or developmental delay impairs ability to perform some daily activities
☐	☐	☐	☐	1. Symptoms of mental/emotional disturbance or developmental delay with minimum impact on daily activities.
■	■	☐	☐	0. No identifiable mental/emotional disturbance or developmental delay
☐	☐	☐	☐	9. Insufficient information available

C 5. Child's Physical Health and Development

A	B	C	D	
☐	☐	☐	☐	4. Severe physical illness, disability or lack of physical development; requires medical care
☐	☐	☐	☐	3. Serious physical illness, disability or lack of physical development; restricts activities without special care
☐	☐	☐	☐	2. Moderate physical illness, disability or lack of physical development; restricts activities somewhat, but overcome with special care
■	☐	☐	☐	1. Mild physical illness, disability or lack of physical development, does not restrict activities
☐	■	☐	☐	0. Healthy and no obvious physical illness, disability or lack of physical development
☐	☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Child Influence. Use specific examples to justify your risk ratings Explain circumstances in which different caregivers or children may have different levels of risk associated with particular risk element.

C1 Age

C2 Child tenses when picked up or fed or approached by parent

C3 Crying of child perceived by parent as a serious problem behavior

C5 Cholic

RISK ASSESSMENT

FAMILY INFLUENCE

F 1 Domestic Violence

Male	Female	Other	
☐	☐	☐	4. Repeated or serious physical violence or substantial risk of serious physical violence in the household
☐	☐	☐	3. Incidents of physical violence in household; imbalance of power and control
☐	☐	☐	2. Isolation and intimidation, threats of harm
☐	☐	☐	1. Verbal aggression
■	■	☐	0. No domestic violence
☐	☐	☐	9. Insufficient information available

F 2 Ability to Cope with Stress

Male	Female	Other	
☐	☐	☐	4. Chronic crisis with limited coping
☐	☐	☐	3. Prolonged crisis strains coping skills
☐	☐	☐	2. Stabilized after period of crisis
■	■	☐	1. Resolution without adverse effect
☐	☐	☐	0. Free from stress influence
☐	☐	☐	9. Insufficient information available

F 3 Availability of Social Supports

Male	Female	Other	
☐	☐	☐	4. Effectively isolated
■	■	☐	3. Some support, but unreliable
☐	☐	☐	2. Some reliable support, but limited usefulness
☐	☐	☐	1. Some reliable and useful support
☐	☐	☐	0. Multiple sources of reliable and useful support
☐	☐	☐	9. Insufficient information available

F 4 Living Conditions

Male	Female	Other	
☐	☐	☐	4. Extremely unsafe; hazardous condition(s) that is (are) dangerous to children and have (has) cause physical injury or illness
☐	☐	☐	3. Very unsafe; multiple hazardous conditions that are dangerous to children
☐	☐	☐	2. Unsafe; one hazardous condition that is dangerous to children
☐	☐	☐	1. Fairly safe; one possibly hazardous condition that may harm children
■	■	☐	0. Safe, no hazardous conditions apparent
☐	☐	☐	9. Insufficient information available

F 5 Family Identity and Interaction

Male	Female	Other	
☐	☐	☐	4. Negative family interactions
☐	☐	☐	3. Family interactions are generally inappropriate
■	■	☐	2. Inconsistent family interactions
☐	☐	☐	1. Family interactions usually positive
☐	☐	☐	0. Family interactions typically supportive
☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Family Influence. Use specific examples to justify your risk ratings. Explain circumstances in which different caregivers or children may have different levels or risk associated with particular risk element.

F1 No history of family violence in relationship

F2 Re-location due to break-up with boyfriend

F3 Has one girlfriend in tow, but has not established relationships with neighbours/community resources. Family provide no physical or emotional support.

F5 Parents needs take precedent over needs of child. When parent's needs are met they can provide adequate level of parenting.

RISK ASSESSMENT

INTERVENTION INFLUENCE

I1 Caregiver's Motivation

Male	Female	Other	
☐	☐	☐	4. No motivation to meet child's needs
☐	☐	☐	3. Very little motivation to meet child's needs
☐	■	☐	2. Motivated to meet child's needs, but caregiver has multiple impediments to solving problems
☐	☐	☐	1. Motivated to meet child's needs, but caregiver has some impediments to solving problems
☐	☐	☐	0. Motivated to meet child's needs and caregiver has no impediment to solving problems
☐	☐	☐	9. Insufficient information available

I1 Caregiver's Cooperation with Intervention

Male	Female	Other	
☐	☐	☐	4. Refuses to cooperate
☐	■	☐	3. Cooperates minimally, but resists intervention
☐	☐	☐	2. Cooperates, but poor response to intervention
☐	☐	☐	1. Cooperates, with generally appropriate response to intervention
☐	☐	☐	0. Cooperates with intervention
☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Intervention Influence. Use specific examples to justify your risk ratings. Explain circumstances in which different caregivers or children may have different levels or risk associated with particular risk.

I1 Inconsistent motivation. Sees on needs as primary, but knows she shouldn't hit child on the face.

I3 Childhood experience with authority figures seem to result in passive/aggressive approach to cooperating with worker and interventions suggested. Does not really trust others.

RISK ASSESSMENT

ABUSE/NEGLECT INFLUENCE

A I — Access to Child by Offenders/Potential Offenders

Male	Female	Other	
☐	■	☐	4. Open access with no adult supervision
☐	☐	☐	3. Open access with ineffective adult supervision
☐	☐	☐	2. Open access with effective adult supervision
☐	☐	☐	1. Limited access with effective adult supervision
☐	☐	☐	0. No access to child
☐	☐	☐	9. Insufficient information available

A 2 — Intent and Acknowledgement of Responsibility

Male	Female	Other	
☐	☐	☐	4. Deliberate or premeditated abuse/neglect
☐	☐	☐	3. Hides or denies responsibility for abuse/neglect
☐	■	☐	2. Rationalizes abuse/neglect or does not understand role
☐	☐	☐	1. Understands role in abuse/neglect and accepts responsibility
☐	☐	☐	0. Abuse/neglect accidental
☐	☐	☐	9. Insufficient information available

A 3 — Severity of Abuse/Neglect

Male	Female	Other	
☐	☐	☐	4. Extreme harm or substantial danger of extreme harm
☐	■	☐	3. Serious harm or substantial danger of serious harm
☐	☐	☐	2. Moderate harm or substantial danger of moderate harm
☐	☐	☐	1. Minor harm or substantial danger of minor harm

A 4 — History of Abuse/Neglect Committed by Present Caretakers

Male	Female	Other	
☐	☐	☐	4. Severe or escalating pattern of past abuse/neglect
☐	☐	☐	3. Serious recent incident or a pattern of abuse/neglect
☐	☐	☐	2. Previous neglect/abuse
☐	■	☐	1. Abuse/Neglect concerns or minor recent isolated incident
☐	☐	☐	0. No history of abuse or neglect
☐	☐	☐	9. Insufficient information available

Summary Description: Describe the most significant risk elements related to the Abuse/Neglect Influence. Use specific examples to justify your risk ratings. Explain circumstances in which different caregivers or children may have different levels of risk associated with particular risk element .

A1 No relatives or babysitters available to provide relief or supervision

A2 Believes just trying to teach child to behave and be good. Tends to blame child rather than accept responsibility for own behaviour. Thinks only problem was where child was hit

A3 Struck child on face during eating conflict, mother has limited control when child cries extensively

A4 Has used physical discipline before - may have been excessive

RISK ANALYSIS WORKSHEET

Parent(s) Name(s): **Date:**

A. List (in point form) all factors that received a 3 or 4 rating, and any other risk factors that should be considered.

RISK ASSESSMENT ANALYSIS

A. Any additional risk factors present:

-Parent is pregnant
-Gets tired easily

B. Describe significant family or individual strengths or other factors that have been identified that may be used as part of the service plan to reduce future risk.

-Child is physically healthy, clean and well supervised so parent has capacity to provide basic level of care
-Reasonable intelligence so able to learn
-Has some inner strengths – left boyfriend who was negative influence and relocated to make a new start

C. Identify and evaluate the importance and interaction of key risk elements and describe your conclusions regarding current level of risk including reasons for your conclusions.

-Young , single, pregnant mother who has abuse history attempting to care for child who is youn, colicky and perceived as difficult.

-Weak emotional bonding between parent and child.

-Parent has some unrealistic expectations of child

-No support network. The dynamics and age of child result in high risk of re-abuse.

OVERALL RISK RATING

NAME OF CHILD: Darren

- [ ] NO RISK
- [ ] MODERATE RISK
- [ ] LOW RISK
- [x] HIGH RISK

Social worker's signature: _____ **Date:** _____

Supervisor's signature: _____ **Date:** _____

ANCHORS

Risk Assessment Scale Anchor Descriptions

Caregiver Influence

CG1. Abuse/Neglect of Caregiver

4. **Severe abuse/neglect as a child.**

   Severe abuse/neglect as a child resulted in a serious emotional disturbance and/or physical scars/disability.

3. **Recurrent, but not severe abuse/neglect as a child**

   Recurrent abuse/neglect as a child; may have resulted in emotional or physical impairment.

2. **Episodes of abuse/neglect as a child.**

   Recounts being abused or neglected as a child, but not severely or recurrently, with no apparent impairment.

1. **Perceived abuse/neglect as a child with no specific incidents.**

   Does not recount being abused or neglected. Expresses dissatisfaction with the care of treatment s/he received when young.

0. **No perceived abuse/neglect as a child.**

   Recounts being loved and well cared for with no incidents of neglect or abuse.

CG2. Alcohol or Drug Use

4. **Substance use with severe social/behavioral consequences.**

Compulsion to use substances, loss of control over use and continued use despite adverse consequences. Drug dependence which may be evidenced by suspected sales and/or manufacture of drugs; dropout from social responsibilities (unemployment, spouse has left, child is abandoned) or severe behavioral problems (extreme aggression or passivity, no concern for future, confusion much of the time).

3. **Substance use with serious social/behavioral consequences.**

Regular and heavy abuse of one or more substance: alcohol or drugs. High risk of not meeting social responsibilities (danger of losing job, financial problems, spouse threatens to leave, child care suffers, driving while intoxicated with child in the car).

2. **Occasional substance use with negative effects on behaviour.**

Uses drugs other than marijuana or alcohol occasionally or binges on alcohol or marijuana. Negative effects on social behaviour (job absenteeism, constant arguments at home, dangerous driving) and on child care. Short-term stupor impairs performance.

1. **Occasional substance use.**

Occasionally smokes marijuana or drinks alcohol to point of impairment. Mild effects on child caring ability or everyday functioning.

0. **No misuse of alcohol or use of drugs.**

May drink but in moderation. No use of illegal drugs or drug-related activity. No observable effects on everyday functioning.

Caregiver Influence

CG3. Caregiver Expectations of Child

4. **Unrealistic expectations with violent punishment.**

Unrealistic, not age appropriate expectations may result in violent behaviour or punishment for child's failure to meet expectations. Physical discipline is the caregiver's only response to child's misconduct and pattern of physical discipline is escalating in severity.

3. **Unrealistic expectations with angry conflicts.**

Unrealistic expectations may lead to regular conflicts and anger towards child over behaviour. Caregiver frequently administers excessive physical discipline. Verbal discipline is frequently inappropriate and excessive in response to child's age and misconduct.

2. **Inconsistent expectations leading to confusion.**

Has knowledge of age-appropriate behaviour, but is inconsistent in expectations. Child is left frustrated and confused by inconsistency. Verbal and physical discipline are inconsistently administered and are often not appropriate to child's age and misconduct.

1. **Realistic expectations with minimal support.**

Good knowledge of age-appropriate behaviours with realistic standards most of the time. May not encourage or assist child with tasks when necessary to meet standards. Verbal discipline is generally controlled and appropriate to child's age and misconduct.

0. **Realistic expectations with strong support.**

Good knowledge of age-appropriate behaviour with consistent and realistic standards. Sets safe and reasonable limits with appropriate consequences. Has flexible demands and provides child with options. Encourages and helps child with tasks when needed. Verbal discipline is controlled and appropriate to child's age and misconduct.

....**Caregiver Influence**

CG4. Caregiver's Acceptance of Child

4. **Rejects and is hostile to child.**

Child is viewed as evil or bad. Child is consistently depreciated and put down. Child is resented and even hated. Caregiver is hostile to child. Child under 16 years abandoned with no arrangement of care; parents refuse to accept return of child.

3. **Disapproves of and resents child.**

Child is seen as disruptive and the cause of many problems. Caregiver disapproves of or criticizes and is resentful of child, poor parental attachment and bonding towards child, withholds affection.

2. **Indifferent and aloof to child.**

Caregiver is neither accepting nor rejecting. Related to child in matter-of-fact, functional terms, but has little emotional involvement and rarely demonstrates acceptance. Repeated shuffling of child from one household to another (unwillingness to maintain custody). Parents provide false information/no information when leaving child with babysitter or other caregiver.

1. **Limited acceptance of child.**

Describes child positively most of the time, but only when asked; only occasionally does so spontaneously.

0. **Very accepting child.**

Frequently and spontaneously speaks about accomplishments of child with approval. Accepts child even when disapproves of behaviour.

.....Caregiver Influence

CG5. Physical Capacity to Care for Child

4. **Incapacitated due to chronic illness or disability resulting in inability to care for child.**

   Acute or chronic illness or disability, or experience of severe pain critically impairs caregiver's ability to perform child care role.

3. **Physical impairment or illness which seriously impairs child caring capacity.**

   Physical illness or disability seriously restricts or interferes with caregiver's ability to care for child. Child care may be at risk because of communicable disease that endangers health, or terminal illness that will impair child caring capacity of caregiver.

2. **Moderate physical impairment or illnesses resulting in only limited impact on child caring capacity**.

   Generally healthy, but has one or more physical illnesses or disabilities which have a mild impact on child caring capacity.

1. **Very limited physical impairment or illness with virtually no impact on child caring capacity.**

   Caregiver has limited physical illness or has a debilitating disease (e.g. M.S., arthritis, diabetes or hypertension) that has not progressed to stage of sustained impairment. Limited impairment of motor functioning has little or no effect on child caring capacity.

0. **Healthy with no identifiable risks to child caring capacity.**

   Caregiver in generally good health with no identifiable illnesses, disabilities or inadequate health habits that would impact child caring.

Note: Consider presence of substance use withdrawal symptoms, such as insomnia, chronic fatigue, irritability, severe headaches, seizures, nausea and vomiting in assessing presence of physical illness or disability.

.....Caregiver Influence

CG6. Mental Capacity to Care for Child

4. **Incapacitated due to mental/emotional disturbance or developmental disability resulting in inability to care for child.**

Caregiver has serious mental/emotional disturbance and delusions or hallucinations may affect behaviour. Psychological state may exhibit severe impairment in communication (incoherent, unresponsive) or judgement. Illness critically impairs ability to provide child care. Caregiver could be dangerous to self and others; suicidal preoccupation. Caregiver has severe intellectual limitations (i.e. has severe developmental disability) emotional instability and/or has very poor reasoning abilities which severely affect his/her ability to protect or care for child.

3. **Serious mental/emotional disturbance or developmental disability which seriously impairs child caring capacity**.

Symptoms may include serious disturbances in judgement, thinking or emotions that may frequently affect caregiver's ability to perform child care tasks. Caregiver is not a danger to others or self. Caregiver has intellectual limitations which adversely affect his/her ability to care for child.

2. **Moderate mental/emotional disturbances or developmental disability with limited impairment of child caring capacity.**

Symptoms such as feelings of powerlessness, low self-esteem, anxiety attacks or mood swings have only a mild impact on the child caring capacity of caregiver. Caregiver has some intellectual limitations or developmental disability which somewhat restricts ability to protect/care for child.

1. **Symptoms of mental/emotional disturbance or developmental disability with no impact on child caring capacity.**

Caregiver suffers from transient symptoms of psychological stress, emotional problems or from mental illnesses with little or no impairment of child caring capacity. Caregiver may have some intellectual limitations which do not affect his/her ability to care for child.

0. **No identifiable mental/emotional disturbance.**

Caregiver has no symptoms of mental illness, psychological disturbance or intellectual limitations. Appears to be emotionally stable.

Child Influence

C1. Child's Vulnerability

4. **Child younger than 2 years of age, or older child with special needs.**

Child is an infant or toddler under the age of two, or an older child with special needs.

3. **Child older than 2 years of age, not regularly accessible to community oversight.**

Child is older than two years of age and is generally cared for in the family home; public exposure is minimal; or child may be cared for outside the home, but scheduled periods of absence are greater than two days at a time.

2. **Child is under 12 years of age, attends school, day care or early childhood development program.**

Child is under the age of 12, regularly attends school or other child care programs at least three days a week, with no more than two days between days of attendance.

1. **Child is over 12 years and younger than 16 years or older child with special needs.**

Child is between the ages of 12 and 16 or older with special needs and is regularly in the community and/or school environment.

0. **Child is 16 years old or older with adequate self-sufficiency skills.**

Child can care for self independently. Is able, when necessary, to prepare food for self and dress appropriately for conditions. Can negotiate transportation system and knows how to access emergency services.

Child Influence

C2. Child's Response to Caregiver

4. **Extremely anxious with uncontrolled fear, withdrawal, or passivity.**

Poor attachment & bonding to caregiver; no interaction between child and caregiver. Child is extremely fearful, shakes or cowers hysterically, or cries uncontrollably from fear. Child is extremely passive, withdrawn, or aloof toward caregiver. Persistently crying infant not soothed or comforted by parent. Minimal eye contact between parent and infant. Physical response may be rigidity or pulling away from parent.

3. **Very anxious with negative, disruptive, and possibly violent interaction.**

Child/caregiver interaction is very negative. Interaction is disruptive, unpredictable, or possibly violent. Child may deny knowledge, tell conflicting stories, refuse to answer questions, or use rehearsed answers in response to questions about caregiver or injuries. Child does not respond, over-responds, or withdraws if parent displays affection or anger.

2. **Moderately anxious with apprehension and suspicion toward caregiver.**

Child is apprehensive and suspicious toward caregiver; appears inappropriately fearful of caregiver. Asks caseworker not to tell caregiver what she/he says. Claims no problems but demeanor does not match statement. Afraid to answer questions and checks caregiver's response after answering. Overly complaint with or mistrustful of caregiver. Child does not respond to parents affection.

1. **Marginally anxious with some hesitancy towards caregiver.**

Child is sometimes cautious around caregiver. Hesitant to talk; exhibits excessive shyness. Child may fail to elicit affection, or respond to caregiver's affection on occasion.

0. **Child trusts and responds to caregiver in age-appropriate way**

Child trusts and responds to caregiver in age-appropriate positive way. Minor conflicts with caregiver are resolve and are seldom long-term. Child is calm, relaxed, and self-assured. Child engages positively with caregiver and elicits affection, and responds with facial expression, posture and behavior.

.....Child Influence

C3. Child's Behavior

4. **Dangerous behavior problems.**

Is violent and dangerous to others or self (suicidal thoughts or attempts) or has a history of violent, delinquent, or criminal behavior. Incidence of exhibitionism or voyeurism. Admits to or is diagnosed as chemically dependent or associates with peers who are. Inappropriately wary of adult contacts; behavioral extremes. Exaggerated fear of closeness or physical contact. Infant or young child is rigid, non-responsive, or listless.

3. **Serious behavior problems.**

Occasionally violent and dangerous to others. Evidence of some self-destructive or self-abusive behaviors. Destructive of objects or possessions, and/or animals. May be chemically dependent. Isolated or scapegoat by peers/siblings. Withdrawal from social interaction; lack of trust, particularly with significant others. Sleep disorders such as insomnia or nightmares. Runs away frequently or exhibits regular truancy from school. Difficult infant (colic, hyperactive); fussy, sleeps very little.

2. **Moderate but pervasive behavior problems.**

Significant pattern of aggression or withdrawal at school, with friends, or siblings. Periodic truancy from school or runs away for short periods of time. Child may act much younger than age-appropriate; use behavior to gain attention; or by having behavior problems at school, in the community, or at home. Difficulty in concentrating at school; overeating, loss of appetite, or other changes in diet. Repeated use of alcohol or other substances.

1. **Minor behavior problems.**

Mild symptoms of hyperactivity or depression. Possible minor school problems or truancy. Experimentation with alcohol or other substances. Generally exhibits age-appropriate behavior.

0. **No significant behavior problems.**

Behavior seems age-appropriate with acceptable school attendance and school/community/home behavior. No use of alcohol or other substances.

....Child Influence

C4. Child's Mental Health and Emotional Development

4. **Incapacitated due to mental/emotional disturbance or developmental delay and unable to function independently.**

Child has severe mental/emotional disturbance (including possibly delusions, hallucinations) and/or developmental delay that makes him/her unable to function age-appropriately. May be dangerous to self (suicidal) or others. Psychological states shows severely impaired communications (incoherent, unresponsive, chronic depression) and judgement (grossly inappropriate acts). Child has diagnosed mental illness (autism, schizophrenia, conduct disorder, etc.) or emotional instability.

3. **Serious mental/emotional disturbance or developmental delay impairs ability to function in most daily activities.**

Child exhibits a serious mental/emotional disturbance or developmental delay. This often is characterized by poor judgement, disturbances in thinking or mood (severely depressed talks of suicide) that effectively prevent child from functioning in most daily activities: attending school, successfully interacting with family or friends, going out in public. Child appears to act in a hyperactive manner.

2. **Moderate mental/emotional disturbance or developmental delay impairs ability to perform some daily activities.**

Emotional disturbance (self-doubt, low self-esteem, or anxiety attacks) or moderate developmental delay impair ability of child to function in some daily activities but not others. Symptoms include refusal to attend school, bed-wetting, aggression, or withdrawal from others. Child has diagnosed learning disability (dyslexia, attention deficit disorder, etc.) which impacts negatively on school performance without aggression or withdrawal.

1. **Symptoms of mental/emotional disturbance with minimal impact on daily activities.**

Child suffers from transient symptoms of emotional stress (difficulty concentrating, loss of appetite, frequent fatigue, nightmares) or mild developmental delay which has minimal impact on school or socialization. May be anxious or have some conflict around peer relations; child may be slightly immature.

0. **No identifiable mental/emotional disturbance.**

Child has no symptoms of illness or developmental delay. Is emotionally stable and exhibits age-appropriate emotional behavior and intellectual development.

....Child Influence

C5. Child's Physical Health and Development

4. **Severe physical illness, disability, or lack of physical development; requires medical care.**

Severe/chronic physical illness, substance use having serious effect on child's health and development, drug withdrawal or positive toxicology, disability or handicap, or severe pain/discomfort from condition severely restricts child's activities or school performance. Special efforts unable to restore such activities. Child's weight and height are below 5th percentile of age; reason unknown or attributed to quality of care. Child is listless & needs medical care. Diagnosis of Fetal alcohol &/or fetal drug syndrome. Child diagnosed with Sexually Transmitted Disease or other physical indications of sexual activity inappropriate to age.

3. **Serious physical illness, disability, or lack of physical development; restricts activities without special care.**

Physical illness or disability seriously restricts activities and school performance and requires special care which caregiver views as burdensome. Child's weight and height are below 5th percentile for age; reason unknown, but parent is cooperative and willing to learn.

2. **Moderate physical illness, disability, or lack of physical development; restricts activities somewhat but overcome with special care.**

Moderate physical illness or disability, or moderate pain/discomfort restrict child somewhat. Poor hygiene: recurring episodes of scabies, lice, persistent diaper rash, skin disorder. Activities and school performance achieved with special care and treatment. Child's weight and height are below 5th percentile for age; medical reasons are known.

1. **Mild physical illness, disability of lack of physical development; does not restrict activities.**

Mild physical illness or disability that does not restrict child's activities or school performance. Child's height and weight is between 5th and 10th percentile; reason is known.

0. **Healthy and no obvious physical illness, disability, or lack of physical development.**

Child is healthy and has no or only minor illness or disability which does not restrict child's activities or school performance. Child's weight or height are at or above the 10th percentile.

Family Influence

F1. Domestic Violence

4. **Repeated or serious physical violence or substantial risk of serious physical violence in household.**

Household member required medical treatment for injuries sustained; or medical attention required but not sought. Unexplained injuries. Recurring or frequent requests for police intervention; order of protection may exist. Threats or use of weapons by one household member against another. Absolute domination of emotional, financial, and sexual spheres by one member, other member submissive. Caregiver is pregnant, incidents of physical violence have occurred since pregnancy.

3. **Incidents of physical violence in household; imbalance of power and control.**

Household member physically assaulted by another member but no medical attention required. Threats (to kill or seriously injure) expressed between members. Previous requests have been made to police for assistance. Emotional and financial control maintained by one member, possibly sexual abuse of one household member by another. Incidents of violence occur in presence of children.

2. **Isolation and intimidation; threats of harm.**

Household members controlled through limited access to financial resources, intimidation, and/or isolation. Other members attempts to control activities, movement, and contacts with other people. Member put in fear by looks, actions, gestures, destruction of property. Threats of harm and/or pushing and shoving of one household member by another.

1. **Verbal aggression**

Household member's activities constrained through verbal aggression. Member may exhibit anxiety or apprehension in the presence of other member. Caregiver has experienced prior abusive relationships.

0 **No domestic violence.**

There is mutual communication. Conflicts between household member are handled without physical threats, intimidation, or violence. One adult in household - no domestic violence issues.

Note: Household member could include adults in the household; siblings; any other individuals who may be included in the family constellation, regardless of residence such as a batterer who may be in and out of the home over time.

....Family Influence

F2. Ability to Cope With Stress

4. **Chronic crisis with limited coping.**

One or more stressors have caused caregiver to act severely depressed or immobilized. Crisis is adversely affecting child caring on a chronic basis; caregiver exhibits inappropriate, very limited, or no coping skills.

3. **Prolonged crisis strains coping skills.**

One or more stressors have occurred which resulted in a prolonged or current crisis. Caregiver's coping strategies are strained and adversely affect child caring capacity.

2. **Stabilized after period of crisis.**

One or more stressors have occurred, but the family has stabilized after crisis. Child caring capacity adversely affected during periods of crisis.

1. **Resolution without adverse effect.**

One or more stressors have occurred, but the family has resolved any associated crisis with no adverse effect on child caring capacity.

0. **Free from stress influence.**

Family is currently, and has been free from the influence of any major stressors during the last year.

Note: Stressors may include, but are not limited to, pregnancy, recent birth, premature, or special needs children, unemployment or other employment changes, financial hardship, death of a spouse or family member, recent mobility, change in marital relationships, prolonged illness or serious injury, inconsistent child care arrangements, over crowding, blended families, chaotic lifestyle or consistent conflict, acute psychiatric episode, or loss of housing. May also include other events not listed, but perceived by family as major stressors.

....Family Influence

F3. Availability of Social Supports

4. **Effectively isolated.**

Geographically and/or socially isolated from community supports.
Alienated from or ongoing conflict with extended family, friends, or neighbors.

3. **Some support, but unreliable.**

Support from family/friends is inconsistent/unreliable. Limited community services available; transportation/mobility difficulty.

2. **Some reliable support, but limited usefulness.**

Family supportive, but not close by. Some support from friends. Community services available but difficult to access.

1. **Some reliable and useful support.**

Satisfactory relationships with family and friends. May participate in one or more community, church, or other social groups. Community services available and accessible.

0. **Multiple sources of reliable and useful support.**

Strong relationships with family, friends, and neighbours; available for necessary support. Caregivers are involved with activities outside the home.

....Family Influence

F4. Living Conditions

4. **Extremely unsafe: hazardous condition(s) that is (are) dangerous to children and has(have) caused physical injury or illness.**

   Dangerous conditions in the home have caused physical injury or illness in children. There may have been repeated episodes of eviction and/or homelessness, or severe overcrowding that have created anxiety in children, disruption of schooling, etc.

3. **Very unsafe:** multiple hazardous conditions that are dangerous to children.

2. **Unsafe:** one hazardous condition that is dangerous to children.

1. **Fairly safe:** one possibly hazardous condition that may harm children.

0. **Safe:** no hazardous conditions apparent.

Note: Hazardous conditions include, but are not limited to:

- Exposed wiring, frayed electrical cords, dangerous electrical outlets.
- Broken windows and/or screens over the windows.
- Unsanitary housing conditions.
- Exposed heating elements or fan blades.
- Absence of railing or stairs, broken stairs, or open windows.
- Chemical substances or dangerous objects (knives, guns) improperly stored and within reach of children.
- Human or animal feces or garbage which has been inappropriately disposed of.
- Inadequate, insufficient or unsanitary sleeping provisions (Example: not enough or clean enough beds, cots mattresses, and blankets for all, including an infant's sleeping place which does not have sides to prevent falling out).
- Infestation by rodents or vermin.
- Vicious or uncontrolled animals in the home.
- Inoperable electricity and heating in the home in cold weather, and lack of proper ventilation in summer and winter.
- Inadequate space to provide some privacy to family members of various ages/sexes.
- Small objects that can be swallowed within the reach of the child.
- Objects lying about the home that the child might fall over or be injured by rotten, moldy, insect-infested, or in any other way contaminated).
- Inadequate equipment and provisions for cooking and refrigerating food.
- Inadequate or unsafe water supply.
- Inadequate or unsafe sewer system.
- Fire hazards (Example: piles of clothing or paper, flammable materials improperly stored, i.e. gasoline).

....Family Influence

F5. Family Identity and Interactions

4. **Negative family interactions**

One or both caregivers fail to provide children with emotional nurturance. Vacating of roles by adults; interactions between household members primarily negative. Serious disruption of family functioning resulting from significant change in family composition.

3. **Family interactions generally inadequate**

One or both adult caregivers rely/relies on children to provide emotional support in daily living, using the child to gather information, provide(s) only limited emotional nurturance to children. Roles and responsibilities are confused and misunderstood. Limited positive family interactions. Some members isolated from family functioning, including scapegoating of the child. Change in family composition disrupting functioning of one or more household members.

2. **Inconsistent family interactions.**

Adult caregivers expect a disproportionate amount of emotional support and comfort from children during periods of stress or crisis. Caregivers provide inconsistent emotional support for children. Interactions between members unsupportive or indifferent. Family is adapting poorly to change in family composition.

1. **Family interactions usually positive.**

Child and caregiver roles are normally distributed and fulfilled with only occasional minor exceptions. Family roles are sometimes confused and ineffective. Interaction between family members usually positive with only occasional relationship problems within household; or family is adapting to recent alteration or breakdown in family structure.

0. **Family interactions typically supportive.**

Child and caregiver roles are appropriate. Adult caregiver provide appropriate amounts or emotional nurturance and support to the child. Care giver has stable marriage or relationship with paramour; household member appear close, supportive, and caring.

Intervention Influence

I1. Caregiver's Motivation

4. **No motivation to meet child's needs.**

Rejects caregiving role, taking a hostile attitude towards child care responsibilities; denies his/her job. Denies family problems. Refuses to provide basic needs such as: refuses to enroll child in school, refuses to seek timely and appropriate medical care for serious health problems that any reasonably person would have recognized as needing professional medical attention.

3. **Very little motivation to meet child's needs.**

Does not reject caregiving role but is indifferent or apathetic to child's needs; not concerned enough to resist competing demands on money, time and attention; takes no responsibility for child's unmet needs, such as permits chronic truancy, undue delay in obtaining medical/professional care as well as follow up to recommendations.

2. **Motivated to meet child's needs, but caregiver has multiple impediments to solving problems.**

Caregiver is motivated to meet the needs of the child but there are serious impediments (e.g. problem recognition, parenting ability, parenting confidence, willingness and ability to seek help) that may limit progress.

1. **Motivated to meet child's needs, but caregiver has some impediments to solving problems.**

Caregiver is motivated to meet the needs of the child, but there are some impediments (e.g., problem recognition, parenting ability, parenting confidence, willingness/ability to seek and utilize help) that may interfere with progress.

0. **Motivated to meet child's needs, and caregiver has no impediments to solving problems.**

Caregiver is motivated to meet the needs of the child and there are no impediments that will significantly affect progress.

I2. Caregiver's Cooperation with Intervention

4. **Refuses to cooperate**

Refuses to accept our agency's involvement. Actively resists and sabotages our agency's efforts, e.g. by making it impossible to contact family.

3. **Cooperates minimally, but resists intervention.**

May verbally accept our agency's involvement. May resist utilization of services. Requires constant prodding/assistance from agency to uses services, or participates in a service in a minimally acceptable manner.

2. **Cooperates, but poor response to intervention.**

Accepts our agency's involvement and utilizes services, but utilization is poor. Accepts referrals but may delay action; may postpone or not keep appointments, may drop services too soon.

1. **Cooperates with generally appropriate response to intervention**

Accepts our agency's involvement and utilizes services in a manner that will benefit client, but full service benefits not always realized due to various factors such as ambivalence, disorganization, etc. May require support and active encouragement from our agency to properly utilize services.

0. **Cooperates with intervention.**

Accepts our agency's involvement. Actively participates in services, if needed.

Note: Services may include:

- Medical Services
- Educational Services
- Mental Health Services
- Early Intervention Services
- Public Health Services
- Specific Services: Physiotherapy/Speech Therapy....etc.

Abuse/Neglect Influence

A1. <u>Access to Child by Offender/Potential Offender (Person Who Has Abused/Neglected or May Abuse/Neglect Child).</u>

4. **Open access with no adult supervision.**

Victim and offender/potential offender live together with no other adult supervision.

3. **Open access with ineffective adult supervision.**

Victim and offender/potential offender live together with other adult who sometimes leaves them alone. There is uncertainty whether the other adult in household can or will protect child. Offender/potential offender lives elsewhere, but has unrestricted visitation without supervision.

2. **Open access with effective adult supervision.**

Lives with victim or frequently visits, but effectively supervised (e.g. other adult almost always present, other adult willing and able to protect child).

1. **Limited access with effect adult supervision.**

Offender/potential offender lives outside home and visits victim in frequently and only with other effective adult supervision.

0. **No access to child.**

Offender/potential offender lives outside the home and never visits, or is totally prevented from gaining access due to incarceration or by the effective barring of access by another caregiver.

...Abuse/Neglect Influence

A2. Intent and Acknowledgment of Responsibility

4. **Deliberate or premeditated abuse/neglect.**

   Caregiver explains occurrences of abuse/neglect as deliberate or premeditated and blames victim for their occurrences.

3. **Hides or denies responsibility for abuse/neglect.**

   Refuses to offer explanation despite evidence and/or denies role in and responsibility for occurrences.

2. **Rationalizes abuse/neglect or doesn't understand role.**

   Caregiver justifies or rationalizes role, assumes little responsibility, or is confused or unaware about his/her role. Caregiver is making light of the abuse or neglect and may not be taking child's concerns about it seriously.

1. **Understands role in abuse/neglect; accepts responsibility.**

   Caregiver acknowledges role in occurrences, takes responsibility, and feels guilty.

0. **Abuse/neglect accidental.**

   Incident appears accidental and caregiver appears sorry and remorseful.

.....Abuse/Neglect Influence

A3. Severity of Abuse/Neglect

4. **Extreme harm or substantial danger of extreme harm.**

Severe neglect or bizarre abuse/neglect resulting in death, disfigurement, or dysfunction of organ or limb; or intentional acts that created a substantial danger of death, disfigurement, or dysfunction of organ or limb; or tortuous disciplinary practices; or sexual abuse accompanied by violence or exploitation (i.e. prostitution, pornography, involving the child in other illegal activities); or life threatening failure to meet child's needs (e.g. failure to thrive).

3. **Serious harm or substantial danger of serious harm.**

Non-accidental serous physical injury requiring immediate medical attention; or intentional acts or disciplinary practices that created a substantial danger of serious physical injury; or sexual abuse; or failure to meet minimum needs of child(food, clothing, shelter, medical, supervision, emotional care) has caused or has created a substantial danger of causing serious physical injury or serious disease requiring immediate medical attention.

2. **Moderate harm or substantial danger of moderate harm.**

Moderate harm to less sensitive parts of the child's body, or substantial danger thereof, as a result of intentional actions or disciplinary practices, which may require medical attention; or moderate harm of substantial danger thereof has been created as a result of failing to meet a child's minimum needs in one or several areas, (food, clothing, shelter, medical supervision, emotional care).

1. **Minor harm or substantial danger of minor harm.**

Minor injury or substantial danger of minor harm, clearly not requiring medical attention, caused acts or disciplinary practices; or failure to meet a child's minimum need(s) (food clothing, shelter, medical, supervision, emotional care, hygiene), resulting in minor harm of substantial danger of minor harm.

.....Abuse/Neglect Influence

A4. History of Abuse/Neglect Committed by Present caregivers

4. **Severe or escalating pattern of past abuse/neglect**

Severe past abuse/neglect or an escalating pattern of seriousness.

3. **Serious recent incident or a pattern of abuse/neglect.**

There has been recent serious abuse/neglect or there exists a non-escalating pattern of abuse and neglect.

2. **Previous abuse/neglect.**

There are disclosures of previous abuse/neglect of a specific nature.

1. **Abuse/Neglect concerns.**

Children or other sources provide information that raises concerns about possible past abuse/neglect, but there is no real clarity about the nature of such abuse/neglect.

0. **No history of abuse or neglect.**

There is no information available that previous abuse/neglect has occurred.

MODULE VII

RISK DECISION #6: DETERMINING THE LEVEL OF SERVICE

MODULE VII
RISK DECISION #6
DETERMINING THE LEVEL OF SERVICE

Commentary

The assessment of risk will determine whether it is possible for the child to be protected while remaining at home or if the child can only be protected through removal from the home.

Refer To Child Protection Services Standards Section....6.1 & 6.2

NOTE: Risk assessment is an on going process. Changes in family functioning/dynamics or circumstances may result in an increase or reduction in risk. Re-assessment of risk may indicate that a higher level of service is required to protect the child or that the child needs to be removes from the home in order to be protected or that the case should be closed.

INSTRUCTIONS FOR COMPLETING THE CASE PLAN

1. Risk Focus

A. Risks To Be Addressed

Under each influence identify from the risk assessment the specific risk factors which will be the focus for intervention. Generally, only the highest or most important risk factors are targeted. These should be identified by code and description, e.g. CG3 Caregiver Expectations of Child.

B. Measurable Results

For each targeted risk factor describe the specific outcomes which will indicate when this risk factor has been reduced. The measurable results should be written in observable and measurable terms. For example,

CT 3 Caregiver Expectations of Child	Father will be able to describe the emotional needs of 3 year olds. Father will be able to describe the connection between his child's behaviours and emotional needs.

2. CASE PLAN

A. Family Member

Several family members may need to take specific steps related to achieving the desired outcome and reducing a risk factor. Identify each family member who has "work" to do regarding a specific risk factor.

B. Steps to be Taken

For each family member identify the steps/actions for which they are responsible. For example,

Father to contact and enroll in parenting class, or to participate in alcohol/substance abuse counseling program.

C. Services to be Provided

Identify specific service to be provided, or utilized to achieve the measurable results. For example, YMCA Nobody's Perfect parenting program, or Drug and Alcohol Counseling Services.

D. Starting and Ending Dates

Indicate when the "work" is expected to begin and be completed.

The Decision-Making Process

Involving the Family

Every effort should be made to involve the family in the development and implementation of the case plan. Where possible the parents and older children should sign the case plan. This ensures that the family knows and understands what is expected of each other, the Department and other service providers. It also helps to strengthen the family's responsibility for and commitment to the case plan.

Involving the Supervisor

Supervisory consultation should be used in developing the case plan.

Involving Other Service Providers

Other agencies/professionals may be providing some of the service identified in the case plan. These agencies should be involved as early as possible in the development of the case plan, especially in relation to their role and responsibilities.

The Time Frame for Decision Making

The case plan should be completed according to child protection service standards.

Documenting the Decision

The completed case plan fulfills the documentation requirements regarding this decision.

CASE PLAN

Case Name: For the period:

RISK FOCUS		ACTION PLAN				
RISK TO BE ADDRESSED (LIST HIGHEST RISK FACTOR)	MEASURABLE RESULTS	FAMILY MEMBER	STEPS TO BE TAKEN	SERVICES TO BE PROVIDED	START DATE	EXPECTED COMP. DATE
Caregiver Influence						
Child Influence						
Family Influence						
Intervention Influence						
Abuse/Neglect Influence						

Social Worker: _____ **Date:** _____ **Caregiver:** _____ **Date:** _____

Supervisor: _____ **Date:** _____ **Child/Youth:** **(If applicable)** _____ **Date:** _____

Caregiver: _____ **Date:** _____

CASE PLAN

Case Name: **Noseworthy**

For the period: **April 1 – June 30**

RISK FOCUS		ACTION PLAN				
RISK TO BE ADDRESSED (LIST HIGHEST RISK FACTOR)	**MEASURABLE RESULTS**	**FAMILY MEMBER**	**STEPS TO BE TAKEN**	**SERVICES TO BE PROVIDED**	**START DATE**	**EXPECTED COMP. DATE**
Caregiver Influence CG1 Abuse	-Mother to identify how abuse affected her childhood -Mother to identify the ways her abuse is now affecting her child and parenting	**mother**	Make referral for counselling services	Individual counselling at Wagasa Family Services	Apr 20	June 30
Child Influence C 3 Behaviour	-Child's behaviour reduced through medical care -Mother to identify 3 warning signs she is getting angry -Mother to demonstrate 3 alternative to hitting child	**mother**	To make appointment with doctor	Medical assessment and follow up To be discussed in meetings with social worker	Apr 5 Apr 5	Apr 15 June 30
Family Influence F3 Social Supports	-Mother accept visit every 2 weeks by department -Mother will meet with Public Health nurse weekly -Mother will establish one mutually supportive relationship with a neighbour	**mother**	-To be available at agreed times -To arrange contact with nurse	-Social worker to visit every two weeks by appointment -Parenting/child development information	Immediately Apr 20 Apr 30	Ongoing June 30 Ongoing
Intervention Influence I2 Cooperation	-Mother follows through on all appointments with Doctor, nurse and social worker	**mother**			Immediately	Ongoing
Abuse/Neglect Influence A1 Access	-Girl friend to live with mother for next 3 months -Mother to find a utilize suitable babysitter at least one per month in crisis situations	**mother**	Arrange Srceen sitters	Supervision, safety, support Babysitting/relief	Apr 5 May 1	June 30 June 30

Social Worker: _____ **Date:** _____ **Caregiver:** _____ **Date:** _____

Supervisor: _____ **Date:** _____ **Child/Youth:** (If applicable) _____ **Date:** _____

Caregiver: _____ **Date:** _____

MODULE VIII

RISK DECISIONS #7, #8, #9: RE-ASSESSMENT OF RISK

MODULE VIII
RISK DECISIONS #7,#8,#9:
RE-ASSESSMENT OF RISK

Commentary

Risk assessment is an ongoing process. Risk needs to be re-assessed on a regular basis. In addition, changes in family functioning/dynamics or circumstances may result in an increase or reduction in risk. Re-assessment of risk may indicate that a higher level of service is required to protect the child or that the child needs to be removed from the home in order to be protected.

Refer to Child Protection Services Standards Section..7.1

The Decision Criteria

A. Planned Re-Assessment

In cases where a comprehensive assessment of risk has been completed a re-assessment of the risk to the child should be completed on a planned, regularly scheduled basis. This planned re-assessment should take place until services are terminated or risk has been eliminated.

There are also at least two additional situations where risk should be re-assessed on a planned basis:

- when consideration is being given to re-uniting the child and family
- when consideration is being given to terminating services

The New York risk assessment instrument should be utilized in completing all planned re-assessments. This ensures that the same criteria (the 22risk factors) used in the initial risk assessment are used at re-assessment. Using the same criteria also enables a more accurate comparison of the assessments to be made. The case plan should also be reviewed and revised in accordance with any changes noted in the re-assessment of risk.

B. Unplanned Re-Assessment

Changes in individual functioning or family dynamics can result in a decrease or increase in risk to a child. For example, the addition of a new baby, or the separation of parents can impact on parental functioning and may place a child at greater risk of abuse/neglect. On the other hand, having a grandparent move into the family to provide support for a period of time may reduce risk.

Similarly, changes in family conditions or circumstances can create either opportunity or stress. This in turn can increase or decrease the risk to a child. For example, sudden unemployment, housing crisis or re-location can create stress which may increase the risk of abuse/neglect. For example, obtaining steady employment and financial stability may reduce risk.

Changes related to intervention can also impact on risk.

The worker needs to be alert to changes impacting the child and family, and especially to changes having the potential to increase the risk of harm to a child. Some examples of changes which the worker should be alert to include:

CAREGIVER INFLUENCE

- changes regarding alcohol/drug use
- changes in physical capacity to care for a child
- changes in emotional capacity to care for child

CHILD INFLUENCE

- changes in the child's development/behaviour which may trigger an abusive parental response
- changes in the child's emotional health
- changes in the child's physical health

FAMILY INFLUENCE

- changes related to living arrangements/environment
- loss of relationships or support systems
- changes in employment
- changes related to income security/stability
- changes in the marital relationship
- changes regarding the emotional "climate" in the family
- changes related to who is living with the family

INTERVENTION INFLUENCE

- sudden or major changes in the client's relationship with the worker or other service providers
- sudden or significant changes in motivation and cooperation regarding services
- premature withdrawal from services
- unavailable for access by the worker

The N.B. adapted version of The New York risk assessment instrument should be utilized in completing all planned re-assessments. The case plan should also be reviewed and revised in accordance with any changes noted in the reassessment of risk.

Decision-Making Process

The importance of the re-assessment requires that a formal meeting or case conference involving as a minimum the social worker and supervisor should be held to review the results of the re-assessment of risk and develop the revised case plan.

Every effort should be make to involve the family in the reassessment process and the development and implementation of the revised case plan.

Other agencies/professionals providing service should be involved in the reassessment of risk and development of the revised case plan.

Documenting the Decision

The completion of the New York risk assessment instrument and accompanying case plan fulfill the documentation requirements for these risk decisions.

Guide for Self-evaluation

MONITORING THE QUALITY OF THE INITIAL INTAKE REPORT

The following are questions to consider when reviewing the social worker's completed Initial Intake Report:

Information Gathering

- Are intake reports appropriately identified as "voluntary service requests" or a "child abuse/child protection report"?
- Are the details documented regarding "voluntary service requests" relevant, sufficient and clear?
- are the details documented regarding "child abuse/child protection reports" relevant, sufficient and clear?
- Do the documented assessments of the motivation of the reporter (in child protection intakes) provide a sufficiently strong and appropriate reason for the determinations made.
- Are initial record checks completed and adequately documented in terms of relevant, sufficient and clear information.

Case Disposition-Voluntary Services

- Are the "accepted" and "not accepted" for voluntary services decisions appropriate?
- Do supporting rationales for the decision provide sufficiently strong and appropriate reasons for the determinations made?
- Are the documented plans of actions and identified interventions appropriate in terms of relevance, timing and availability?

MONITORING THE QUALITY OF THE SAFETY ASSESSMENT AND SAFETY PLAN

The following are questions to consider when reviewing the social worker's safety assessment and safety plan:

The Safety Assessment

- How many of the safety factors are marked "unknown"?
- Does the supporting information identify specific caregivers, children, behaviours, conditions and or circumstances associated with the safety factors that have been checked off?
- For the safety factors checked present or not present is there sufficient and revenant supporting information provided to make a "Yes" or "No" decision?
- Are the caregivers and children identified in relation to each specific safety factor checked off?
- Are safety factors considered present or not present based on the criteria "recently occurred", "is occurring now", or is "very likely to occur in the immediate future (with the exception of Safety Factor #8 which is related to past abusive behaviour).
- Based on the supporting information provided how many of the "Yes" or "No" judgements are appropriate?
- Are other safety factors identified or which should have been identified?

The Safety Decision

- Does it appear from the assessment that the worker understands that the safety decision reflects a "status" and therefore, a child is considered to be in an "Unsafe" status even though a safety response may be in place to protect the child?
- Does the documented safety decision reflect the present situation at the time the safety assessment is completed?
- Is the safety decision appropriate and supported by the safety assessment?

CASE DISPOSITION-CHILD PROTECTION SERVICES

- Are the decisions to "investigate" and "not to investigate" appropriate?
- Do supporting rationales for the decision provide sufficiently strong and appropriate reasons for the determinations made?
- Are the priority of the response judgments appropriate and accurate given the circumstances of the case?
- Are plans of action completed and are they clear and specific?
- Are the plans of action appropriate in terms of their ability to protect the child(ren) and undertake an adequately and timely investigation of the report?

MONITORING THE QUALITY OF THE RISK ASSESSMENT AND CASE PLAN

The following are questions to consider when reviewing the risk assessment and service plan:

The Risk Factors

- Are initial risk assessments completed within required time frames?
- Is the social worker accurately and reliably rating each risk element according to the anchor descriptions?
- Are all risk factors rated?
- Is "insufficient information available" (rating 9) used appropriately?
- Is sufficient, relevant and reliable information obtained/used to support each risk factor, which is rated?
- Are risk factors rated as if services were not being provided in order to reflect the actual risk that would be present without services? (The one exception being Caregivers Cooperation with Intervention.)
- Is historical information regarding family/individual functioning used appropriately in rating a risk element?
- Are risk elements rated using the highest appropriate risk rating when more than one anchor description is relevant?
- Are the most significant risk ratings for each Influence described accurately, sufficiently and clearly in the Summary Description?
- Do Summary Descriptions provide sufficient and appropriate justification for the most significant risk factors identified?

THE CASE PLAN

- Are case plans developed within the required time frame?
- Has the family been adequately involved in the development of the case plan?
- Have relevant community resources/service providers been involved in the development of the case plan?
- Are case plans linked directly and appropriately to the risk assessment?
- Are the "measurable results" clear, specific and measurable/verifiable?
- Do the "measurable results" provide a clear understanding to the family of exactly what must occur to reduce identified significant risks?
- Are the "measurable results" appropriate and achievable?
- Do case plans clearly identify who is responsible for what actions?
- Are time frames identified and realistic?
- Are the services to be provided and the service providers to be utilized clearly identified?
- Are the identified services and service providers appropriate?

SUGGESTIONS FOR FURTHER READING

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- Alberta
- Manitoba
- New Brunswick
- Nova Scotia
- Prince Edward Island
- Quebec
- Saskatchewan

Child Protection Services Standards:
- MigMag Maliseet First Nations
- New Brunswick
- Nova Scotia
- Quebec

Risk Assessment Manual:
- British Columbia
- Ontario

Websites:

BHCM Planning Manual, *Children At Risk*
http://www.lcms.org/bhcm/discong/car.html

Willie M. Services, *Risk And Protective Summarized*
http://www.state.nc.us/DHR/DMH/williem/rrchrt.htm

NCADI Women And Drug Abuse
http://www.health.org/pubs/wda.htm

NCRPCA National Committee To Prevent Child Abuse,
National Incident Study: Implication For Prevention
http://www.childabuse.org/fs13/html

Causes Of Child Abuse And Neglect,
What Causes Child Abuse And Neglect? What Are the Answers?
http://www.state.nj.us/humanservices/njcap4.html

Persons (Agencies) Contacted:

Dr. John Anderson, M.D., Child Protection Specialist, I.W.K., Hospital, Halifax, Nova Scotia.

Juanita Muerika, Psychologist, College of Psychologist, New Brunswick.

Mark Sieben, Manager of Child Protection Policy and Standards, Victoria, British Columbia.

Ron Stanley, Director of Child Welfare, Health and Social Services, Charlottetown, Prince Edward Island.

Pat Sullivan, Public Health Nurse, Public Health Services, Fredericton, New Brunswick

Jane Wood, Early Intervention Coordinator, Miramichi, New Brunswick

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